

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13869

## CERTIFICATE OF DEATH

13972

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>-- Maryland</b> b. COUNTY <b>--</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rural) Sykesville</b>		c. LENGTH OF STAY IN lb <b>45y 8m 3d</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b>		30-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>not listed in record</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Frederick</b> Middle <b>T.</b> Last <b>Andreae</b>		4. DATE OF DEATH Month <b>10</b> Day <b>15</b> Year <b>19 66</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-3-90</b>
9. AGE (In years last birthday) yrs. <b>76</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frederick E. Andreae</b>		14. MOTHER'S MAIDEN NAME <b>Anna Gundlach</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>unk.</b>		16. SOCIAL SECURITY NO. <b>220-54-6778</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>Weeks</b> <b>Years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Schizophrenic reaction, hebephrenic type</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>--</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>--</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>--</b> p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>--</b>	20f. (City or town) (County) (State) <b>--</b>
21. I certify that (a) (this hospital) attended the deceased from <b>2-12</b> , 19 <b>21</b> to <b>10-15</b> , 19 <b>66</b> , that (b) (we) last saw the deceased alive on <b>10-15</b> , 19 <b>66</b> , and that death occurred <b>10:40 M.</b> from causes and on the date stated above. <b>p.m.</b>			
22a. SIGNATURE <b>Heinz H. Klaatsch</b>		22b. DATE SIGNED <b>10-15-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Heinz H. Klaatsch, M.D.</b>		22d. ADDRESS <b>Springfield State Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10/20/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Western Cemetery, Balto., Md.</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>Wm. J. Zickner &amp; Son</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 19 1966</b>	
ADDRESS <b>Baltimore, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

13239

13239

--- Maryland

1937 No 34

and listed as record

Washington State Hospital

Frederick T. Anderson

white male

0-3-30

Maryland

Ann Geddis

Frederick S. Anderson

12-31-30

Alzheimer's disease

Alzheimer's disease

Alzheimer's disease

Washington State Hospital

Frederick S. Anderson, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13970						13973					
1. PLACE OF DEATH a. COUNTY <u>CARROLL COUNTY</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>				c. LENGTH OF STAY IN 1b <u>8 MONTHS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER MD.</u>				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>108 E. MAIN ST. APT #4</u>						d. STREET ADDRESS <u>108 E. MAIN STREET</u>					
3. NAME OF DECEASED (Type or print) <u>OLIVER</u> First <u>TENNYSON</u> Middle <u>ARMIGER</u> Last			4. DATE OF DEATH <u>OCT. 4</u> Day <u>4</u> Year <u>1966</u>								
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 22 1888</u> yrs. <u>78</u>		9. AGE (In years last birthday) Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GUARD - RETIRED POLICEMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>CALVERT CO.</u>				11. BIRTHPLACE (County & State, or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>BENJAMIN F. ARMIGER</u>						14. MOTHER'S MAIDEN NAME <u>SARAH ELIZABETH HARRISON</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>215-03-7917</u>		17. INFORMANT <u>WIFE IONA E. ARMIGER</u>		Address <u>108 E. MAIN ST. WESTMINSTER, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>4201</u> DUE TO (b) <u>Hypertension &amp; arteriosclerosis</u> DUE TO (c) <u>Cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 16</u> , 19 <u>63</u> to <u>Oct 4</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Oct 4</u> , 19 <u>66</u> , and that death occurred at <u>6:30 PM</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>William Speicher</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		DATE SIGNED <u>10-5-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>DR. W. GLENN SPEICHER</u>				22d. ADDRESS <u>135 E. MAIN ST. WESTMINSTER, MD.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>10/7/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FRIENDSHIP METH. CEM. FRIENDSHIP, MD.</u>		23d. LOCATION (City, town or county) (State) <u>FRIENDSHIP, MD.</u>			
24. FUNERAL DIRECTOR <u>James G. Saffelt</u>				ADDRESS <u>WESTMINSTER, MD.</u>		25a. REC'D BY REGISTRAR <u>102 OCT 6 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1000

05281



# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

13974

13974

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Carroll</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Woodbine</u> c. LENGTH OF STAY IN lb <u>Golden Age Guest Home</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u> d. STREET ADDRESS <u>Frederick Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) <u>Marion Cyers</u>				<b>4. DATE OF DEATH</b> Month <u>Oct</u> Day <u>31</u> Year <u>1966</u>									
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>10-10-1894</u>		<b>9. AGE</b> (In years last birthday) <u>72</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months Days</td> <td>Hours Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months Days	Hours Min.
IF UNDER 1 YEAR	IF UNDER 24 HRS.												
Months Days	Hours Min.												
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>At Home</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>MARYLAND</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b>			
<b>13. FATHER'S NAME</b> <u>Charles H. Waldvogel</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary L. Zaner</u>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>213-20-9586</u>				<b>17. INFORMANT</b> <u>Mrs. Marjorie Willett, Ellicott City, Md</u>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Cardiac Failure</u> 0021 DUE TO <u>Pulmonary Tuberculosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>myocarditis</u> (b) (c)										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>24 hrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)					
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Aug 29</u> <u>1966</u> <b>to</b> <u>Oct 31</u> <u>1966</u> <b>that (I) (we) last saw the deceased alive on</b> <u>Oct 31</u> <u>1966</u> <b>and that death occurred at</b> <u>5 P.M.</u> <b>from the causes and on the date stated above.</b>													
<b>22a. SIGNATURE</b> <u>M N MASTIN</u>						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>Nov 1-66</u>					
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>M N MASTIN</u>						<b>22d. ADDRESS</b> <u>Huntminster Lane</u>							
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>11-3-1966</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Sharon Baptist</u>		<b>23d. LOCATION (City, town or county)</b> (State) <u>West Friendship, Md</u>					
<b>24 FUNERAL DIRECTOR'S SIGNATURE</b> <u>F.C. Higinbotham</u>						<b>25a. REC'D BY REGISTRAR</b> DATE <u>NOV 7 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13033

13033

Chicago, Ill.

October 10, 1933

10-10-1933

Dear Mr. [Name]

Very I. [Name]

Dear Mr. [Name]

at home

Very I. [Name]

Very I. [Name]

11-1-33

11-1-33

[Signature]

Very I. [Name]

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13972

## CERTIFICATE OF DEATH

13975

<b>1. PLACE OF DEATH</b> a. COUNTY <u>CARROLL</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR RURAL</u> c. LENGTH OF STAY IN 1b <u>YEARS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BOWERSOX ROAD</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR RURAL</u> d. STREET ADDRESS <u>BOWERSOX ROAD</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>RAYMOND WALTER BALTZELL</u> First Middle Last <b>5. SEX</b> <u>M</u> <b>6. COLOR OR RACE</b> <u>W</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>NOV 6 - 1910</u> <b>9. AGE</b> (In years lost birthday) <u>55</u> yrs. <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>FARMER</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>FARM</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>MARYLAND</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			<b>4. DATE OF DEATH</b> <u>OCT 20</u> 19 <u>66</u> Month Day Year <b>IF UNDER 1 YEAR</b> Months Days Hours Min. <b>13. FATHER'S NAME</b> <u>CHARLES BALTZELL</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>EDITH ADAMS</u> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> <b>16. SOCIAL SECURITY NO.</b> <u>217-36-4295</u> <b>17. INFORMANT</b> <u>CARRIE BALTZELL</u> Address <u>MD NEW WINDSOR</u>				
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) <u>Angina Pectoris</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II at item 18.) <b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>					
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>10/11/63</u> , 19____, <b>to</b> <u>10/20/66</u> , 19____, <b>that (I) (we) last saw the deceased alive on</b> <u>10/16/66</u> , 19____, <b>and that death occurred at</b> <u>11:45 AM</u> , from causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>M. E. Robertson</u> <b>22c. PHYSICIAN'S NAME (Type)</b> <u>M E ROBERTSON</u>			<b>22b. DATE SIGNED</b> <u>10/20/66</u> <b>22d. ADDRESS</b> <u>NEW WINDSOR MD</u>				
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u> <b>23b. DATE THEREOF</b> <u>OCT 22, 1966</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>ST PETERS</u> <b>23d. LOCATION (City or Town) (County) (State)</b> <u>LIBERTYTOWN MD</u>		<b>24. FUNERAL DIRECTOR</b> <u>D D Hartzler &amp; Sons New Windsor MD</u> <b>25a. REC'D BY REGISTRAR</b> <u>DATE OCT 24 1966</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>J Charles Judge</u>					

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13075

STATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RED FINKSBURG</b> c. LENGTH OF STAY IN 1b <b>22 MONTHS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>RFD #2</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FINKSBURG</b> d. STREET ADDRESS <b>RFD #2</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JABEZ NELSON BARNES</b>		4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>23</b> Year <b>1966</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC 17 1893</b>
9. AGE (in years last birthday) <b>72</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>	11. BIRTHPLACE (County & State, or foreign country) <b>CARROLL-MARYLAND, U.S.A.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JABEZ N. BARNES</b>	
14. MOTHER'S MAIDEN NAME <b>KITTY ELLEN HAINES</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)	
16. SOCIAL SECURITY NO. <b>220-20-9659</b>		17. INFORMANT <b>MOSES U. BARNES</b> (BROTHER) <b>ROUTE #2 FINKSBURG MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL VASCULAR ACCIDENT</b> DUE TO (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DIS.</b> DUE TO (c) <b>4221</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>MARCH 1965</b> to <b>OCTOBER 1966</b> that (I) (we) last saw the deceased alive on <b>OCT 23 1966</b> and that death occurred at <b>9:35 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Daniel I Welliver</b> M.D.		22b. DATE SIGNED <b>10/23/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>DANIEL I WELLIVER</b>		22d. ADDRESS <b>19 RIDGE ROAD WESTMINSTER MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10/26/1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Providence Cemetery</b>	23d. LOCATION (City, town or county) <b>Carroll Co., Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz</b>		25. REC'D BY REGISTRAR <b>OCT 25 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
13974 CERTIFICATE OF DEATH 13977

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Manchester, Md</u> c. LENGTH OF STAY IN lb <u>2 wks</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Longview Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>7 industrial, Maryland</u> d. STREET ADDRESS <u>128 N Main St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Edwina M. Boileau</u>			4. DATE OF DEATH <u>Oct 17 1966</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 9, 1903</u>	9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept Store</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Matthew Coughlan</u>			14. MOTHER'S MAIDEN NAME <u>Biddeman</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>219-14-0552</u>	17. INFORMANT <u>Jeanne Clute (daughter)</u> Address <u>304 Rossiter Dr Baltimore Md</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture of left lower extremity - Congest</u> 1538 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Permeized Carcinomatous</u> DUE TO (c) <u>Primary Carcinoma of Colon.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 3, 1966</u> to <u>Oct 17, 1966</u> , that (I) (we) last saw the deceased alive on <u>Oct 14, 1966</u> , and that death occurred at <u>4:30</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph E. Bush MD</u>			22b. DATE SIGNED <u>10-17-66</u>				
22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>			22d. ADDRESS <u>HAMPSTEAD Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/20/1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>	23d. LOCATION (City, town or county) (State) <u>Pikesville, Balto. Co. Md.</u>				
24. FUNERAL DIRECTOR <u>H.W. Jenkins &amp; Sons Co.</u> ADDRESS <u>4905 York Road Baltimore 12, Md.</u>			25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
			DATE <u>OCT 19 1966</u>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>				c. LENGTH OF STAY IN 1b <u>24 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>64 So. Church St.</u>						d. STREET ADDRESS <u>624 So. Church St.</u>					
3. NAME OF DECEASED (Type or print) First <u>ALBERT</u> Middle <u>F</u> Last <u>BOND</u>						4. DATE OF DEATH Month <u>OCT.</u> Day <u>18</u> Year <u>1966</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 23/1892</u>		9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Restaurant employee</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Fredrick Co. Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Frank T. Bond</u>						14. MOTHER'S MAIDEN NAME <u>Fannie Kiler</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>  </u>				16. SOCIAL SECURITY NO. <u>219-20-0992A</u>		17. INFORMANT <u>Mrs Albert F. Bond</u>		Address <u>Same address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 4201 CONDITIONS, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> (c) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>3-16 min</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>  </u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>10/19/66</u> , 19 <u>  </u> , to <u>10/19/66</u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>Never</u> 19 <u>  </u> , and that death occurred at <u>12:30</u> AM, from the causes and on the date stated above.											
22a. SIGNATURE <u>William R O'Rourke</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/19/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>William R O'Rourke</u>						22d. ADDRESS <u>150 W. Main St., Westminster, Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/21/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. James Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Rural near bonds, Md.</u>			
24. FUNERAL DIRECTOR <u>J. E. Myers, Jr. - Westminster, Md.</u>						25a. REC'D BY REGISTRAR <u>  </u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			
DATE <u>OCT 21 1966</u>											

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*[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side.]*



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b> </div>									
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Carroll</u> <span style="float: right;">MARYLAND</span>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Carroll</u></span>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-New Windsor</u>			c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-New Windsor</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R.D. 2</u>					d. STREET ADDRESS <u>R.D. 2</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Albert J. Bowman</u>			First <u>Albert</u> Middle <u>J.</u> Last <u>Bowman</u>		<b>4. DATE OF DEATH</b> <u>Oct. 31, 1956</u>		Month <u>Oct.</u> Day <u>31</u> Year <u>1956</u>		
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>Colored</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Oct. 22, 1956</u>		<b>9. AGE</b> (In years last birthday) <u>10</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>  </u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Carroll County, Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Unknown</u>					<b>14. MOTHER'S MAIDEN NAME</b> <u>Barbara Bowman</u>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> <u>Miss Barbara Bowman Same As #2</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hydrocephalus</u> <u>3441</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Aspiration</u> DUE TO (c) <u>  </u>								<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>9 3/4 yrs</u> <u>years</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)		
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
<b>ACTUAL SIGNATURE</b> <u>W. Glenn Speicher</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>22. DATE SIGNED</b> <u>10/31/66</u>	
<b>EXAMINER'S NAME</b> (Type) <u>W. Glenn Speicher</u>				<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>1358</b> <u>W. Glenn Speicher</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>11/3/1966</u>		<b>23c. NAME OF CEMETERY OR CREMATORIUM</b> <u>Western Chapel</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Carroll Co., Md.</u>			
<b>24. FUNERAL DIRECTOR</b> <u>C. M. Waltz Box 241 Sykesville, Md.</u>						<b>25a. REC'D BY REGISTRAR</b> <u>NOV 2 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

13977

13980

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>			c. LENGTH OF STAY IN 1b <b>1yr. 27dys.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>650 Baker St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>IDA</b> Middle <b>E.</b> Last <b>BOWMAN</b>				4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>27</b> Year <b>19 66</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-15-1887</b>		
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>		IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Brill</b>				14. MOTHER'S MAIDEN NAME <b>Mariah Hoffman</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <b>Unk.</b>		17. INFORMANT <b>Records, Springfield State Hospital</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobar pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Heart failure</b> DUE TO (c) <b>Mitral valve stenosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>days</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Chronic brain syndrome assoc. with senile brain disease, without qualifying phrase. Obstruction of common bowel duct by gall stone with biliary cirrhosis of liver.</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>biliary cirrhosis of liver.</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9-30-65</b> , 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>10-27-66</b> , 19 <b>66</b> , and that death occurred at <b>9:15 PM</b> , 19 <b>66</b> , from causes and on the date stated above.								
22a. SIGNATURE <b>Dr. Alfredo M. Labrit</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>10-27-66</b>		
22c. PHYSICIAN'S NAME (Type) <b>DR ALFREDO M LABRIT</b>				22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-31-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Olivet Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>W.Va. Hardy</b>		
24. FUNERAL DIRECTOR <b>Harry W. Knight</b>				ADDRESS <b>Sykesville, Md</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 3 1966</b>		
				25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

13978

13981

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>1yr. 10mos. 12dys.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>1213 W. Mosher St.</b>	
3. NAME OF DECEASED (Type or print) First <b>BETTY</b> Middle <b>(NMN)</b> Last <b>BRISCOE</b>		4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>24</b> Year <b>19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>1-1-1890</b>
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maid</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Lanse Mayo</b>		14. MOTHER'S MAIDEN NAME <b>Jane (maiden name unk.)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>P.C. Pinkney Briscoe</b>		Address <b>1213 Mosher St.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary arteriosclerosis with old infarcts</b> DUE TO (c) <b>Severe nephrosclerosis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome assoc. with cerebral arteriosclerosis, without qualifying phrase</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>12-12-64</b> , 19___, to <b>10-24-66</b> , 19___, that (I) (we) last saw the deceased alive on <b>10-24-66</b> , 19___, and that death occurred at <b>3:20 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Agustin del Campo.</b> M.D.		22b. DATE SIGNED <b>10-24-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M. D.</b>		22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10-28-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>Geo. L. Kelso</b>		25. REC'D BY REGISTRAR <b>1345 N. Calhoun St.</b>	
26. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>OCT 26 1966</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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5. *Journal of the American Medical Association*, 277, 1996, 1231-1234.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 13982											
1. PLACE OF DEATH a. COUNTY CARROLL COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SYKESVILLE c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) LINGERS BOARDING HOUSE					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 646 NORTH BEND ROAD (FORMERLY) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) LAURA M. BROADFOOT			4. DATE OF DEATH OCTOBER 24, 1966			5. SEX FEMALE			6. COLOR OR RACE WHITE		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH APRIL 24, 1888			9. AGE (In years last birthday) 78 yrs.			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED HOMEMAKER		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED HOMEMAKER			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME -----RICE			14. MOTHER'S MAIDEN NAME ALBERTA-----			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. 218-34-0472		
17. INFORMANT MR. ROLAND W. BROADFOOT			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 331X DUE TO arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 30 min		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)			21. I certify that (I) (this hospital) attended the deceased from Spring, 1966 to Oct 26, 1966 that (I) (we) last saw the deceased alive on Oct 25, 1966, and that death occurred at 11 PM, from the causes and on the date stated above.			22a. SIGNATURE E Reese Wilkens M.D. 22b. DATE SIGNED OCT 31 1966		
22c. PHYSICIAN'S NAME (Type) E Reese Wilkens			22d. ADDRESS 15 Westminister Lane			23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 10-31-66		
23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEMETERY			23d. LOCATION (City, town or county) (State) BALTIMORE, MARYLAND			24. FUNERAL DIRECTOR HOWARD H. HUBBARD, 4107 WILKENS AVENUE, 21229			25a. REC'D BY REGISTRAR DATE OCT 31 1966		
25b. REGISTRAR'S SIGNATURE Charles Judge											

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## FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY <b>Carroll</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City-30</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Springfield State Hospital</b>					c. LENGTH OF STAY IN b <b>4 yrs 11 da</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sykesville, Md.</b>					e. STREET ADDRESS <b>Baltimore</b> <b>Balto. City 10 E. Hamilton St.</b>					
3. NAME OF DECEASED (Type or print) First <b>Clemmon</b> Middle <b>May</b> Last <b>Brown</b>					4. DATE OF DEATH Month <b>Oct.</b> Day <b>30</b> Year <b>1966</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-17-02</b>		9. AGE (In years last birthday) <b>63</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Music Teacher</b>					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Brown</b>					14. MOTHER'S MAIDEN NAME <b>Clara Stone</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>					16. SOCIAL SECURITY NO. <b>217-34-5090</b> <b>UNKNOWN</b>		17. INFORMANT Address <b>Sykesville, Md.</b> <b>Springfield St. Hosp. Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> <b>4201</b> DUE TO <b>Coronary artery sclerosis and mitral valve</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>insufficiency</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CBS with cerebral arteriosclerosis with psychotic reaction</b>									INTERVAL BETWEEN ONSET AND DEATH <b>Weeks</b>  <b>Years</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <b>W. Glenn Speicher</b> EXAMINER'S NAME (Type) <b>W. Glenn Speicher, M.D.</b>					22. DATE SIGNED <b>19-30-66</b> <b>Charles Judge</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Transit 11-1-66</b>			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <b>Salem Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Winston-Salem, N.C.</b>			
24. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home</b> <b>Baltimore, Md. 21212</b>					25a. REC'D BY REGISTRAR DATE <b>NOV 3 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13984

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural New Windsor</i>		c. LENGTH OF STAY IN TB <i>2 yrs +</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Finksburg</i>		d. STREET ADDRESS <i>06.1</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Horton Boarding Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>ADAM MYRLE BUCKINGHAM</i>		4. DATE OF DEATH Month <i>Oct.</i> Day <i>10</i> Year <i>1966</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 9, 1881</i>
9. AGE (In years last birthday) <i>85</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <i>Carroll Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Levin Winfield Cagle</i>		14. MOTHER'S MAIDEN NAME <i>Alvie Taylor</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>Mrs. Harold E. Harvey</i>		Address <i>1712 Landmark Rd. Towson, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic C.V.D.</i> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <i>Years</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Aug. 12, 1963</i> to <i>10/10, 1966</i> , that (I) <del>was</del> last saw the deceased alive on <i>10/8/66</i> 19__, and that death occurred at <i>6:4</i> A.M. from causes and on the date stated above.			
22a. SIGNATURE <i>M.E. Robertson</i>		22b. DATE SIGNED <i>10/10/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>ME. ROBERTSON</i>		22d. ADDRESS <i>New Windsor, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>Oct. 12 66</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Sandy Mount Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Finksburg Rd. Carroll Co. Md.</i>
24. FUNERAL DIRECTOR <i>J. E. Myers, Jr., Westminster, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>OCT 13 1966</i>	25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>



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STATE OF TEXAS

12021

COUNTY CLERK

NOTICE: The undersigned, County Clerk of the County of [ ] State of Texas, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears in the records of the County of [ ] State of Texas.

WITNESSED my hand and the seal of said County at the City of [ ] this [ ] day of [ ] 19[ ]

\_\_\_\_\_  
County Clerk

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13983

13982

1. PLACE OF DEATH a. COUNTY <u>Carrroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carrroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester (Rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester (Rural)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Lineboro Road</u>				d. STREET ADDRESS <u>Lineboro Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Adria</u> Middle <u>Viola</u> Last <u>Caldwell</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>18</u> Year <u>1966</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 21-1876</u>	
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (State or foreign country) <u>Pa</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>							
13. FATHER'S NAME <u>Sanwold</u>				14. MOTHER'S MAIDEN NAME <u>Hammersley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Robert Caldwell</u> Address <u>Manchester, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio</u> <u>4221</u> DUE TO <u>Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatic</u> <u>Myelitis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>  </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1950</u> , to <u>Oct 18</u> , 19 <u>66</u> , that I last saw the deceased alive on <u>Oct 8</u> , 19 <u>66</u> , and that death occurred at <u>6 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wilbur H Ford</u>				ADDRESS (Street, city or town, state) <u>Manchester, Md</u>		DATE SIGNED <u>10/18/66</u>	
PHYSICIAN'S NAME (Type) <u>Wilbur H Ford M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/21/1966</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Gibson</u>				ADDRESS <u>  </u>		24a. REC'D BY REGISTRAR DATE <u>OCT 19 1966</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900

1900

<p>1. NAME OF DECEASED (Last, first, middle initial)                  _____</p>		<p>2. SEX  <input type="checkbox"/> Male <input type="checkbox"/> Female</p>	
<p>3. AGE (in years and months)                  _____</p>		<p>4. DATE OF BIRTH (Month, day, year)                  _____</p>	
<p>5. PLACE OF BIRTH (City, town, county, state)                  _____</p>		<p>6. OCCUPATION                  _____</p>	
<p>7. MARITAL STATUS  <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced</p>		<p>8. DATE OF MARRIAGE (Month, day, year)                  _____</p>	
<p>9. CAUSE OF DEATH (Immediate cause)                  _____</p>		<p>10. CAUSE OF DEATH (Underlying cause)                  _____</p>	
<p>11. PLACE OF DEATH (City, town, county, state)                  _____</p>		<p>12. DATE OF DEATH (Month, day, year)                  _____</p>	
<p>13. SIGNATURE OF PHYSICIAN                  _____</p>		<p>14. SIGNATURE OF REGISTRAR                  _____</p>	
<p>15. ADDRESS (Street, city or town, state)                  _____</p>		<p>16. FROM THE CAUSE AND OCCURRED AT                  _____</p>	
<p>17. TO _____, 19____, it was found that _____</p>		<p>18. I saw the _____</p>	
<p>19. _____</p>		<p>20. _____</p>	
<p>21. _____</p>		<p>22. _____</p>	
<p>23. _____</p>		<p>24. _____</p>	
<p>25. _____</p>		<p>26. _____</p>	
<p>27. _____</p>		<p>28. _____</p>	
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<p>35. _____</p>		<p>36. _____</p>	
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<p>61. _____</p>		<p>62. _____</p>	
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<p>65. _____</p>		<p>66. _____</p>	
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<p>91. _____</p>		<p>92. _____</p>	
<p>93. _____</p>		<p>94. _____</p>	
<p>95. _____</p>		<p>96. _____</p>	
<p>97. _____</p>		<p>98. _____</p>	
<p>99. _____</p>		<p>100. _____</p>	

RECEIVED  
 BALTIMORE  
 1900

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13983

## CERTIFICATE OF DEATH

13986

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

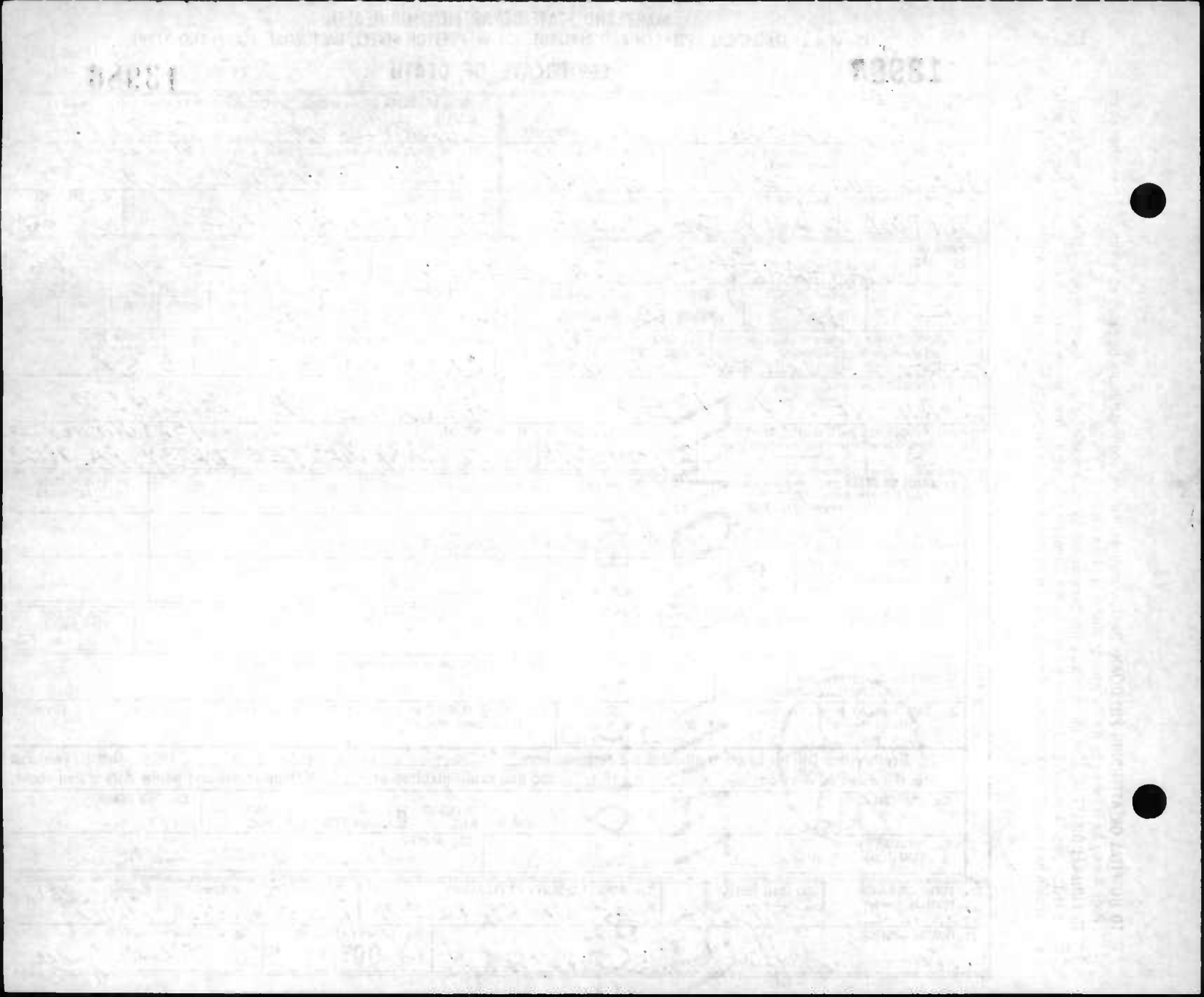
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>CARROLL COUNTY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. LENGTH OF STAY IN 1b <u>4 DAYS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL COUNTY GEN. HOSP.</u>		d. STREET ADDRESS <u>37 SULLIVAN AVE.</u>	
3. NAME OF DECEASED (Type or print) <u>MARGARET SUSANN CAREY</u>		4. DATE OF DEATH <u>OCT 6 1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 19, 1891</u>
9. AGE (In years lost birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OPERATED A GENERAL STORE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FOOD</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>CARROLL CO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN HENRY IBEX</u>		14. MOTHER'S MAIDEN NAME <u>ADELAIDE E. FISHER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-34-4075</u>	
17. INFORMANT <u>SISTER MARY METTEE DARBY PA. 19023</u>		Address <u>136 WHITELY TER.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4200</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m. <u>  </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>OCT 3, 1966</u> , to <u>OCT 6, 1966</u> , that (I) (we) last saw the deceased alive on <u>OCT 6, 1966</u> , and that death occurred at <u>8:30 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>John S. Harshey</u>		22b. DATE SIGNED <u>10/6/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN S. HARSHEY, M.D.</u>		22d. ADDRESS <u>8 Archer St. Westminster, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>OCT. 9, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WESTMINSTER CEM.</u>	23d. LOCATION (City or Town) (County) (State) <u>WESTMINSTER, MD. CARROLL</u>
24. FUNERAL DIRECTOR <u>James G. Saffell, Jr., WESTMINSTER, MD.</u>		25a. REC'D BY REGISTRAR <u>OCT 10 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

13251

13251

13251



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Manchester Maryland</u>						c. LENGTH OF STAY IN 1b <u>2 1/2 mo.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Longview Nursing Home 12 S.W. main st</u>						d. STREET ADDRESS <u>Old Homestead Rd</u>					
3. NAME OF DECEASED (Type or print) <u>Hazel</u> First Middle Last						4. DATE OF DEATH <u>Oct 17</u> Month Day Year <u>1966</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 13, 1894</u>		9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Balto Co. on farm.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Edward A. Burke</u>						14. MOTHER'S MAIDEN NAME <u>Ida May Bolt</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>220-48-3641</u>		17. INFORMANT <u>Mrs Henry Long - daughter - Upper co md.</u>				Address <u>Old Homestead</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thromboses</u> <u>422.1</u> DUE TO (b) <u>Arteriosclerotic Cardio</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Vascular Disease</u>										INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (II) (this hospital) attended the deceased from <u>8/9</u> , 19 <u>66</u> , to <u>Oct 17</u> , 19 <u>66</u> , that (II) (we) last saw the deceased alive on <u>Oct 13</u> , 19 <u>66</u> , and that death occurred at <u>7:55 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>W.H. Foard</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/17/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>W.H. Foard M.D.</u>						22d. ADDRESS <u>Manchester, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Oct. 20, 66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Paul Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Arcadia, Md.</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Tipton-Eline Funeral Home Hampstead, Md.</u>						25a. REC'D BY REGISTRAR <u>OCT 21 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			



12051

12051

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13985

CERTIFICATE OF DEATH

13988

1. PLACE OF DEATH a. COUNTY <u>CARROLL CO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>112 E. MAIN ST.</u>		d. STREET ADDRESS <u>112 E. MAIN ST.</u>	
3. NAME OF DECEASED (Type or print) <u>CLEMIE</u> First <u>ELIZABETH</u> Middle <u>DAVIS</u> Last		4. DATE OF DEATH <u>10</u> Month <u>21</u> Day <u>19</u> Year <u>66</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 7, 1890</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE-WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MEDFORD CARROLL CO. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>H. STEWART ROBERTS</u>		14. MOTHER'S MAIDEN NAME <u>ELLA ENGLAR</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>MRS. EILEEN W. WEBER</u> Address <u>1801 CODY DR. SILVER SPRING, MD.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY INSUFFICIENCY</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR</u> DUE TO (c) <u>DISEASE</u>			INTERVAL BETWEEN ONSET AND DEATH <u>YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10/19</u> , 19 <u>65</u> to <u>10/21</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10/19</u> , 19 <u>66</u> , and that death occurred at <u>5:21</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Vincent J. Fiocco</u> M.D.		22b. DATE SIGNED <u>10/21/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>VINCENT J. FIOCCO</u>		22d. ADDRESS <u>8 ANCHOR ST. WESTMINSTER, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>OCT. 24, 66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WESTMINSTER CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>WESTMINSTER, MD.</u>
24. FUNERAL DIRECTOR <u>J. E. Myers, Jr., Westminster, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>
DATE <u>OCT 25 1966</u>			

13887

13887

115 E MAIN ST  
CLERMONT ELIZABETH DAVIS  
115 E MAIN ST

Aug 7 1880 80

M. STEWART ROBERTS  
HOUSE-WIFE  
MEDFORD GARROLD II 11

MRS EILEEN WEBER  
2112 SPRING ST  
RECORDING DE

VINCENT J. FISCO  
BRANCH 21 WESTMINSTER RD  
1001 21st St WESTMINSTER CONN 06701  
21st St Westminister, Conn.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13986

CERTIFICATE OF DEATH

13989

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminister</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminister</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Carroll County General</b>		d. STREET ADDRESS <b>122 Cityview</b>	
3. NAME OF DECEASED (Type or print) First <b>Zeruah</b> Middle <b>Willard</b> Last <b>Dion</b>		4. DATE OF DEATH Month <b>10</b> Day <b>19</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Sept. 3, 1883</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	9. AGE (In years last birthday) yrs. <b>83</b>
11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>David Woolard</b>		14. MOTHER'S MAIDEN NAME <b>Not Obtainable</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Alonzo H. Dion</b>		Address <b>Westminister, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HYPERNEPHROMA, RIGHT KIDNEY,</b> <b>180 X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>C PROBABLE METASTASES</b> (c) <b>DIABETES MELLITUS</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 mo.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>DIABETES MELLITUS</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>10/12, 1966</b> to <b>10/19, 1966</b> , that (I) (we) last saw the deceased alive on <b>10/19, 1966</b> , and that death occurred at <b>10:30</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Vincent J. Kross Jr.</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>10/19/66</b>
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Oct. 22, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln</b>	23d. LOCATION (City or Town) (County) (State) <b>Bladensburg, Maryland</b>
24. FUNERAL DIRECTOR <b>Cunningham Funeral Home, Inc.</b>		ADDRESS <b>Alex., Va.</b>	25a. REC'D BY REGISTRAR DATE <b>OCT 24 1966</b>
		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

1938

1938

General

Administrator

Barrett County Council

Barrett

Willard

Winn

Sept. 2, 1938

People's

Monroe

At Home

Virginia

for Virginia

David Woodard

Alonso H. Wood

Administrator, W.

April

Oct. 21, 1938

St. Albans

Stamford, Vermont

Continental Insurance Co., Inc. Alex. Va.

Oct. 21, 1938

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
13987											
13990											
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Howard</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodstock</u>					
c. LENGTH OF STAY IN 1b <u>3 Weeks</u>						d. STREET ADDRESS <u>—</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pine Knob Rd.</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>Elizabeth</u> Last <u>Doffmeyer</u>						4. DATE OF DEATH Month <u>Oct.</u> Day <u>14</u> Year <u>1966</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 11, 1883</u>		9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>				11. BIRTHPLACE (County & State, or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Peacher</u>						14. MOTHER'S MAIDEN NAME <u>Mary Grady</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mrs. Myrtle Ensor - Finksburg</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 4201 DUE TO (b) <u>Myocardial Infarction - Decompensated</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Hypertension - Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month <u>9</u> Day <u>10</u> Year <u>1966</u> Hour <u>—</u> a.m. <u>—</u> p.m. <u>—</u> 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <u>9-10-66</u> to <u>10-14-66</u> , that (I) (we) last saw the deceased alive on <u>10-14-66</u> , and that death occurred at <u>11</u> M, from the causes and on the date stated above. 22a. SIGNATURE <u>James P. Saffell</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>James P. Saffell</u> 22b. DATE SIGNED <u>10-15-66</u> 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>10-18-66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>BALTO. NAT. Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u> 24. FUNERAL DIRECTOR <u>Harry W. Haight</u> ADDRESS <u>Sykesville, Md.</u> 25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> DATE <u>OCT 18 1966</u>											



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02661

*[Faint, illegible handwritten notes and signatures are visible across the page.]*

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

13988

13991

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Carroll</u> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Sykesville</u>		c. LENGTH OF STAY IN 1b <u>7 Mo. 30d</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Sykesville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>R.R.3 Box 270</u>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Lewis Oliver Dorsey</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>October 23 1966</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-7-90</u>	9. AGE (In years last birthday) Yrs. <u>76</u>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>John Dorsey</u>			
14. MOTHER'S MAIDEN NAME <u>Rachael Gibbons</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>217-16-1150</u>				17. INFORMANT Address <u>Springfield Hospital Records - Sykesville</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE</u> DUE TO (b) <u>BRONCHO PNEUMONIA</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>2/24</u> , 19 <u>66</u> , to <u>10/23</u> , 19 <u>66</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>10/23</u> , 19 <u>66</u> , and that death occurred at <u>11:10A</u> M, from causes on and on the date stated above.					
22a. SIGNATURE <u>Naci N. Bonyakubsal</u>		22b. ADDRESS <u>Springfield State Hospital Sykesville - Md.</u>		22c. DATE SIGNED <u>10-23-66</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10-26-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Johnsville Cemetery</u>			
23d. LOCATION (City or Town) (County) (State) <u>Sykesville, Md.</u>		24. FUNERAL DIRECTOR ADDRESS <u>Harry W. Haight Sykesville, Md.</u>					
25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1933

RECEIVED FOR IT

1933

RECEIVED FOR IT  
1933

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

13989

Item 2 Film C381 10/17/66 mh

13992

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester Md.</u>	
c. LENGTH OF STAY IN 1b <u>1 yr.</u>		d. STREET ADDRESS <u>126 N. Main St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Longview Nursing Home Inc.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Minnie B Flater</u>	First Middle Last	4. DATE OF DEATH <u>Oct. 5</u> 19 <u>66</u>	Month Day Year
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/2/1883</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Thomas Ward</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Ann Devilbuss</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-18-2689</u>	
17. INFORMANT <u>Mrs. Margaret Numsen, Manchester, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cerebral Arteriosclerosis</u> (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 1955</u> to <u>Oct. 5, 1966</u> , that (II) (we) last saw the deceased alive on <u>Oct. 5, 1966</u> , and that death occurred at <u>10:00 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>W H Foward</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>W H Foward M.D.</u>		22d. ADDRESS <u>Manchester, Md 10/5/66</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/8/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Sandymount Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Carroll Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Tipton-Eline</u> ADDRESS <u>Hampstead, Md.</u>		25a. REC'D BY REGISTRAR <u>OCT 10 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

18105

CERTIFICATE OF DEATH

18105



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13990

## CERTIFICATE OF DEATH

13993

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. LENGTH OF STAY IN 1b ---		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Mt. Airy</u> 06.1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll County General Hospital</u>				d. STREET ADDRESS <u>Route 2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Fleming</u> A				4. DATE OF DEATH Month <u>October</u> Day <u>19</u> Year <u>1966</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 19, 1966</u>		9. AGE (In years lost birthday) yrs. <u>1</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>34</u>	IF UNDER 24 HRS. Months <u>1</u> Days <u>1</u> Hours <u>34</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Westminster, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Kendall Fleming</u>				14. MOTHER'S MAIDEN NAME <u>Linda Watkins</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Kendall Fleming Same As # 2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity (Twins) Ill 7 days</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-19, 1966</u> to <u>10-12, 1966</u> , that (I) (we) last saw the deceased alive on <u>10-19, 1966</u> , and that death occurred at <u>11:45</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Karl M. Green</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/19/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Karl M. Green</u>				22d. ADDRESS <u>181 Fairfield Ave. Westminster, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/22/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Poplar Springs</u>		23d. LOCATION (City or Town) (County) (State) <u>Howard Co., Md.</u>	
24. FUNERAL DIRECTOR <u>C. M. Waltz Box 241 Sykesville, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 24 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



19800

13003

See entry (Tun) 11/1/01

10-13  
10-13

10/1/01

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MDARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13897

CERTIFICATE OF DEATH

13994

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>				c. LENGTH OF STAY IN 1b ----			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll County General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Fleming</u> B				4. DATE OF DEATH Month <u>October</u> Day <u>19</u> Year <u>1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 19, 1966</u>	
9. AGE (In years lost birthday) yrs. <u>1</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>27</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>27</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Westminster, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Kendall Fleming</u>				14. MOTHER'S MAIDEN NAME <u>Linda Watkins</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Kendall Fleming Same As #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Immature (Femin) 1 lb 7 oz</u> (c) <u>1 lb 7 oz</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <u>10-19</u> , 19 <u>66</u> to <u>10-22</u> , 19 <u>66</u> , that (we) lost saw the deceased alive, on <u>10-19</u> , 19 <u>66</u> , and that death occurred at <u>10:27</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Karl M. Green</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/19/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Karl M. Green</u>				22d. ADDRESS <u>181 Fairfield Ave. Westminster, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/22/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Poplar Springs</u>		23d. LOCATION (City or Town) (County) (State) <u>Howard Co., Md.</u>	
24. FUNERAL DIRECTOR <u>C. M. Waltz Box 241 Sykesville, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 24 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

13206

WATER IN NORTH

13206

*See section (Fair) 11-28*

*10/10*

*11-11*

*10-10*

*10/10*

*11-11*

RECEIVED BY THE U.S. DEPARTMENT OF THE INTERIOR  
UNITED STATES GEOLOGICAL SURVEY, WASHINGTON, D.C.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

13992

13995

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Carroll</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Manchester</u> c. LENGTH OF STAY IN 1b <u>1 yr 9 Mon</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Long View Nursing Home</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster (Rural)</u> d. STREET ADDRESS <u>Rt 6</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Melvie</u> <u>LAURA</u> <u>Freyman</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>Oct</u> <u>6</u> <u>1966</u>							
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Aug 16 - 1885</u>		<b>9. AGE</b> (In years last birthday) <u>81</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Carroll Co. Md</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			
<b>13. FATHER'S NAME</b> <u>William O Lockard</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Emily Arnold</u>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Name <u>Mrs Ralph Hoffman</u> Address <u>Westminster, Md</u>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>generalized Arteriosclerosis</u> (c) <u>Arteriosclerotic Cardio Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>										<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>	
<b>21. I certify that</b> (1) (this hospital) attended the deceased from <u>12/28</u> , 19 <u>64</u> , to <u>10/6</u> , 19 <u>66</u> , that (1) (we) last saw the deceased alive on <u>10/5</u> , 19 <u>66</u> , and that death occurred at <u>3:45 AM</u> , from the causes and on the date stated above.											
<b>22a. SIGNATURE</b> <u>W H Foard</u>				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22d. ADDRESS</b> <u>Manchester, Md</u>				<b>22b. DATE SIGNED</b> <u>10/6/66</u>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>W H Foard MD</u>				<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>							
<b>23b. DATE THEREOF</b> <u>10/8/66</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Deer Park Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) <u>Westminster RD#6, Md</u>		<b>(State)</b>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>J. E. Myers, Jr., Westminster, Md.</u>						<b>25a. REC'D BY REGISTRAR</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>			
<b>DATE</b> <u>OCT 10 1966</u>											

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, and in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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2231

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 should be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. These pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>MARYLAND</b> b. COUNTY <b>FREDERICK</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL WESTMINSTER</b>						c. LENGTH OF STAY IN 1b <b>5 YEARS</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>ROUTE #4 BOX 319</b>						d. STREET ADDRESS <b>NEW MARKET</b>					
3. NAME OF DECEASED (Type or print) <b>CARRIE BANKERT FRIZZELL</b>						4. DATE OF DEATH <b>OCTOBER 7 1966</b>					
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/11/75</b>		9. AGE (In years last birthday) <b>90</b> yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>						10b. KIND OF BUSINESS OR INDUSTRY					
11. BIRTHPLACE (County & State, or foreign country) <b>CARROLL - MARYLAND.</b>						12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>					
13. FATHER'S NAME <b>David J. Bankert</b>						14. MOTHER'S MAIDEN NAME <b>Alverta Stephan</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>						16. SOCIAL SECURITY NO. <b>None</b>					
17. INFORMANT <b>Mrs. Louise B. Alexander</b>						Address <b>Westminster, Md. 412 Sullivan Rd.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>CEREBRAL VASCULAR THROMBOSIS</b>											
DUE TO (b) <b>ARTERIOSCLEROTIC VASCULAR DIS</b>											
DUE TO (c) <b>15 YEARS</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>OCTOBER 1965</b> to <b>OCTOBER 1966</b> , that (I) (we) last saw the deceased alive on <b>OCTOBER 7 1966</b> , and that death occurred at <b>3:15 PM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>David I. Welliver</b> M.D.						22b. DATE SIGNED <b>10/7/66</b>					
22c. PHYSICIAN'S NAME (Type) <b>DAMEL I. WELLIVER</b>						22d. ADDRESS <b>WESTMINSTER MARYLAND</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>				23b. DATE THEREOF <b>10/10/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Crematory</b>				23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz</b> ADDRESS <b>Box 241 Sykesville, Md.</b>						25a. REC'D BY REGISTRAR <b>DATE OCT 10 1966</b> 25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>					



13208

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13994

13997

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster</b>			c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Taneytown,</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Carroll County General Hospital</b>				d. STREET ADDRESS <b>25 Frederick Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Kenneth Ronaldo Gilds</b>				4. DATE OF DEATH Month Day Year <b>October 14, 1966</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <b>May 19, 1907</b>		9. AGE (In years lost birthday) yrs. <b>59</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Barber</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>G. F. Sherman Gilds</b>				14. MOTHER'S MAIDEN NAME <b>Laura Marquet</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-01-3803</b>		17. INFORMANT Address <b>Miss Jane Gilds, Taneytown, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Artery Occlusion</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Arteriosclerosis</b> DUE TO (c) <b>Generalized Arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 3/4 hrs</b> <b>Sys</b> <b>Sys</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary Emphysema</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 1943</b> to <b>10/14, 1966</b> , that (I) <del>(we)</del> lost saw the deceased alive on <b>10/14, 1966</b> , and that death occurred at <b>8:15 PM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>R. S. McVaugh</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>10/15/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>R. S. McVaugh</b>				22d. ADDRESS <b>Taneytown, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct 17, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Taneytown, Maryland</b>	
24. FUNERAL DIRECTOR <b>John H. Skiles</b>				ADDRESS <b>C. O. Fuss &amp; Son, Taneytown, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 18 1966</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

13007

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13995

CERTIFICATE OF DEATH

13998

1. PLACE OF DEATH o. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNIONTOWN</u>		c. LENGTH OF STAY IN TB <u>YEARS</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNIONTOWN</u>		d. STREET ADDRESS <u>06-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>00</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BLANCHE</u> Middle <u>LOUELLA</u> Last <u>HALTER</u>		4. DATE OF DEATH Month <u>OCT</u> Day <u>25</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 2, 1905</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>J SNADER</u>		14. MOTHER'S MAIDEN NAME <u>LOUELLA ZILE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-32-2847</u>	
17. INFORMANT <u>WILBUR HALTER</u>		Address <u>UNIONTOWN MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Breast</u> 170X DUE TO <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized metastases, Lungs</u> (c) <u>Emphysema</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 wks</u> <u>months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>OCT 24, 1966</u> , to <u>OCT 25, 1966</u> , that (I) (we) last saw the deceased alive on <u>OCT 24, 1966</u> , and that death occurred at <u>1:41 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>W Glenn Speicher</u>		22b. DATE SIGNED <u>10/27/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>W GLENN SPEICHER</u>		22d. ADDRESS <u>Westminster Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>OCT 28 - 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>METHODIST</u>		23d. LOCATION (City or Town) (County) (State) <u>UNIONTOWN MD</u>	
24. FUNERAL DIRECTOR <u>D N Hartzler &amp; Sons</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 31 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Fredrick</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>		c. LENGTH OF STAY IN 1b <u>3 MO.</u>	
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>New Market</u>		d. STREET ADDRESS <u>1012</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Longview Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>NANNIE DORA HAUGH</u>		4. DATE OF DEATH <u>Oct 9</u> 19 <u>66</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 9, 1882</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Fredrick, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Silplane</u>		14. MOTHER'S MAIDEN NAME <u>Blue Hayer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-34-0651A</u>	
17. INFORMANT <u>Noral Haugh Randall</u>		Address <u>Woodboro Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 12</u> , 19 <u>66</u> , to <u>Oct 9</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Oct 7</u> , 19 <u>66</u> , and that death occurred at <u>4A</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph E. Bush MD.</u>		22b. DATE SIGNED <u>Oct 9, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD.</u>		22d. ADDRESS <u>Hamstead, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10/11/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MT HOPE</u>		23d. LOCATION (City, town or county) (State) <u>WOODSBORO MD</u>	
24. FUNERAL DIRECTOR <u>Bowell &amp; Hartzler</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Woodboro, Md</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>OCT 13 1966</u>			



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*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "James", "John", and "Mary" are faintly visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13897

CERTIFICATE OF DEATH

14000

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rural) Sykesville</b>		c. LENGTH OF STAY IN 1b <b>7y 9m 18d</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		30-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>1221 S. Clinton Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Lawrence</b> Middle <b>John</b> Last <b>Hesler</b> <sup>4. DATE DEATH</sup> <b>HESSLER</b> Month <b>10</b> Day <b>24</b> Year <b>19 66</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-27-1882</b>
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Adam Hesler - HESSLER</b>		14. MOTHER'S MAIDEN NAME <b>Dorretta Simpson KATHERINE ?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>215-56-1810</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac failure</b> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>bronchial pneumonia</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>5 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome associated with senile brain disease without qualifying phrase</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>--</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>--</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. -- p.m. <b>-- 19</b>	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>--</b>	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>1-6-1959</b> to <b>10-24</b> , 19 <b>66</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>10-24</b> , 19 <b>66</b> , and that death occurred at <b>1:50 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Frances Reid Nabors</b>		22b. DATE SIGNED <b>10-24-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Frances Reid Nabors, M.D.</b>		22d. ADDRESS <b>Sykesville, Maryland Springfield State Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>10-26-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART CEM.</b>	23d. LOCATION (City or Town) (County) (State). <b>740 GERMAN HILL RD. BALTO. CO. MD.</b>
24. FUNERAL DIRECTOR <b>Charles S. Seiler</b>		25a. REC'D BY REGISTRAR <b>OCT 26 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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DEPARTMENT OF HEALTH

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13998

## CERTIFICATE OF DEATH

14001

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Carroll</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Union Bridge</b>			c. LENGTH OF STAY in 1b <b>9 yrs.</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Union Bridge</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Route #1</b>				d. STREET ADDRESS <b>Route #1</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>Shawn</b> Last <b>Hoffecker</b>				4. DATE OF DEATH Month <b>10-</b> Day <b>27</b> Year <b>19 66</b>						
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <b>4-22-1891</b>		9. AGE (In years lost birthday) <b>75</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrical Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Delaware</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>David Hoffecker</b>				14. MOTHER'S MAIDEN NAME <b>Ella Jones</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-07-1012</b>		17. INFORMANT <b>Marie B. Hoffecker</b>			Address <b>Above</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Arterio sclerosis</b> DUE TO (c) <b>Generalized Arterio Sclerosis</b>								INTERVAL BETWEEN ONSET AND DEATH <b>30 min</b> <b>6 yrs</b> <b>10 yrs</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Peripheral Vascular Disease</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 22, 1958</b> , to <b>Oct 22, 1966</b> , that (I) (we) last saw the deceased alive on <b>July 6, 1966</b> , and that death occurred at <b>3:30 P</b> M, from causes and on the date stated above.										
22a. SIGNATURE <b>E. Ambler Thomas</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>OCT. 22, 1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>E. Ambler Thomas</b>				22d. ADDRESS <b>Taneytown, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-31-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>			
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b>				ADDRESS <b>4905 York Rd. Balt</b>			25a. REC'D BY REGISTRAR <b>OCT 31 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20M 1/65

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> <b>a. COUNTY</b> <u>Carroll</u> <b>MARYLAND</b> <b>b. CITY OR TOWN</b> (if outside corporate limits, write RURAL and give nearest town) <u>Manchester, Md.</u> <b>c. LENGTH OF STAY IN lb</b> <u>24 days</u> <b>d. NAME OF HOSPITAL OR INSTITUTION</b> (if not in hospital, give street address) <u>Ingwers Nursing Home</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) <b>a. STATE</b> <u>Md</u> <b>b. COUNTY</b> <u>Balto.</u> <b>c. CITY OR TOWN</b> (if outside corporate limits, write RURAL and give nearest town) <u>Parkton Md.</u> <b>d. STREET ADDRESS</b> <u>Farm.</u> <b>e. IS RESIDENCE ON A FARM?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
<b>3. NAME OF DECEASED</b> <b>(Type or print)</b> <u>Bertha</u> <b>First</b> <u>G</u> <b>Middle</b> <u>Kelbaugh.</u> <b>Last</b>			<b>4. DATE OF DEATH</b> <u>Oct 28</u> <b>Month</b> <u>1966</u> <b>Day</b> <b>Year</b>			<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>white</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Feb 26 1897</u> <b>9. AGE</b> (In years last birthday) <u>69</u> <b>yrs.</b>			<b>IF UNDER 1 YEAR</b> <b>IF UNDER 24 HRS.</b> <b>Months</b> <b>Days</b> <b>Hours</b> <b>Min.</b>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Balto Co. on farm</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>				<b>13. FATHER'S NAME</b> <u>John Cole</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Laurie Cooper</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service) _____ <b>16. SOCIAL SECURITY NO.</b> <u>246-38-2563</u> <b>17. INFORMANT</b> <u>Henry Kelbaugh (Husband)</u> <b>Address</b> <u>Parkton Md.</u>				<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>Cerebral Hemorrhage</u> <u>4221</u> <b>DUE TO</b> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <b>(b)</b> <u>Arteriosclerotic Cardiovascular Disease</u> <b>DUE TO</b> <b>(c)</b> _____ <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>Arteriosclerotic</u>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.) _____							
<b>20c. TIME OF INJURY</b> <b>Month, Day, Year</b> _____ <b>Hour</b> <b>a.m.</b> _____ <b>p.m.</b> <u>19</u>				<b>20d. INJURY OCCURRED</b> <b>While at work</b> <input type="checkbox"/> <b>Not While at work</b> <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____			
<b>20f. (City or town)</b> _____ <b>(County)</b> _____ <b>(State)</b> _____				<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>10-17-</u> <u>1966</u> <b>to</b> <u>10-28</u> <u>1966</u> <b>that (I) (we) last saw the deceased alive on</b> <u>10-28</u> <u>1966</u> <b>and that death occurred at</b> <u>8:30</u> <b>M.</b> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Joseph E. Bush</u> <b>M.D.</b> <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>						<b>22b. DATE SIGNED</b> <u>10-28-66</u>					
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Joseph E. Bush, M.D.</u> <b>22d. ADDRESS</b> <u>Hampstead, Maryland</u>											
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>23b. DATE THEREOF</b> <u>10/31/66</u>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Mt. Carmel Cemetery</u> <b>23d. LOCATION (City, town or county)</b> <u>Balto. Co.</u> <b>(State)</b> <u>Md</u>				<b>24. FUNERAL DIRECTOR</b> <u>Tipton-Eline</u> <b>ADDRESS</b> <u>Hampstead, Md.</u>			
<b>25a. REC'D BY REGISTRAR</b> <u>Charles Judge</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>						<b>DATE</b> <u>NOV 2 1966</u>					



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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14000

CERTIFICATE OF DEATH

14003

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rural) Sykesville</b> c. LENGTH OF STAY IN 1b <b>Oy Om 18d</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick 21701</b> d. STREET ADDRESS <b>215 W. Patrick Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Arthur</b> Middle <b>Koogle</b> Last <b>Kepler</b>		4. DATE OF DEATH Month <b>10</b> Day <b>7</b> Year <b>1966</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-28-1900</b>
9. AGE (In years last birthday) <b>64 65</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>5</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Martin Kepler</b>		14. MOTHER'S MAIDEN NAME <b>Cecelia-- F. Koogle</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>none</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>212-14-7677</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO <b>491X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome associated with cerebral arteriosclerosis</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>--</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>12</b> p.m. <b>--</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>--</b>	20f. (City or town) (County) (State)
21. I certify that <del>(s)</del> (this hospital) attended the deceased from <b>9-19-</b> , 19 <b>66</b> , to <b>10-7-</b> , 19 <b>66</b> that <del>(s)</del> (we) lost the deceased alive on <b>10-7</b> 19 <b>66</b> and that death occurred at <b>A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Heinz H. Klaatsch</b> M.D.		22b. DATE SIGNED <b>10-7-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Heinz H. Klaatsch, M.D.</b>		22d. ADDRESS <b>Sykesville, Maryland Springfield State Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Oct. 10-1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Frederick, Md. 21701</b>
24. FUNERAL DIRECTOR <b>Elwood T. M.R. Etchison &amp; Son</b>		25a. REC'D BY REGISTRAR <b>Whitmore</b> ADDRESS <b>Frederick, Md. 21701</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>OCT 10 1966</b>	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14002

CERTIFICATE OF DEATH

14004

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural--Sykesville</b>		c. LENGTH OF STAY IN 1b <b>3y. 3m. 16d.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Gertrude</b> Middle <b>Sarah</b> Last <b>Kessler</b>		4. DATE OF DEATH Month <b>10</b> Day <b>17</b> Year <b>1966</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/3/82</b>
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>clerk - retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>England</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>unknown</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Springfield Hospital records, Sykesville, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Arteriosclerotic heart disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Days or weeks</b> <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome associated with senile brain disease with psychotic reaction.</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <b>6/21/1963</b> to <b>10/17/1966</b> , that (2) (we) last saw the deceased alive on <b>10/17/1966</b> , and that death occurred at <b>10:15 p.m.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Naci N. Buyukunsal, M.D.</b>		22b. DATE SIGNED <b>10/18/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Naci N. Buyukunsal, M.D.</b>		22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Oct. 20, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington, Va.</b>
24. FUNERAL DIRECTOR <b>W.W. Chambers Co. Riverdale Md</b>		25a. REC'D BY REGISTRAR <b>OCT 19 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
14002					14005				
1. PLACE OF DEATH a. COUNTY					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE b. COUNTY				
Carroll					Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					c. LENGTH OF STAY IN 1b				
Woodbine					3 Years				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					e. STREET ADDRESS				
Golden Age Fruit Home					Near Westminster				
f. IS RESIDENCE ON A FARM?					g. IS RESIDENCE ON A FARM?				
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
George A. Koontz					Oct 16 1966				
5. SEX					6. COLOR OR RACE				
Male					White				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH				
					9/17/1882				
9. AGE (In years last birthday)					10. IF UNDER 1 YEAR				
84 yrs.					Months Days Hours Min.				
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					11b. KIND OF BUSINESS OR INDUSTRY				
Retired Farmer					Farm				
12. CITIZEN OF WHAT COUNTRY?					13. FATHER'S NAME				
U.S.A.					Nelson Koontz				
14. MOTHER'S MAIDEN NAME					15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				
Ida Rinaman					No				
16. SOCIAL SECURITY NO.					17. INFORMANT				
219-01-4559					Washington P. Koontz				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)					19. INTERVAL BETWEEN ONSET AND DEATH				
332X					Cerebral Arteriosclerosis				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					Gen Arteriosclerosis				
DUE TO (b)					Hypertension				
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year					20d. INJURY OCCURRED				
Hour a.m. p.m. 19					While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from Dec 4 1963, to Oct 16 1966, that (I) (we) last saw the deceased alive on Oct 13 1966, and that death occurred at 12:30 P.M. from the causes and on the date stated above.									
22a. SIGNATURE					22b. DATE SIGNED				
H. H. Martin					Oct 17-66				
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
M. N. MASTIN					Westminster, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE THEREOF				
Burial					10/19/66				
23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City, town or county) (State)				
St. Marys Cemetery					Silver Run, Carroll Co., Md.				
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR				
Richard A. Little					DATE OCT 19 1966				
25b. REGISTRAR'S SIGNATURE									
					J. Charles Judge				



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CERTIFICATE OF DEATH

14006

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - SYKESVILLE</u>		c. LENGTH OF STAY IN 1b <u>13Y-9M-7d</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRINGFIELD STATE HOSP.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>SYLVIA</u> Middle <u>CLARICE</u> Last <u>LOEB</u>		4. DATE OF DEATH Month <u>10</u> Day <u>14</u> Year <u>1966</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>4-9-20</u>
9. AGE (In years lost birthday) <u>46</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>EARL LOEB SAMUEL EISENBERG</u>		14. MOTHER'S MAIDEN NAME <u>JENNIE KOHNY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>SPRINGFIELD HOSP. RECORDS</u>		Address <u>SYKESVILLE MARYLAND.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEART FAILURE, Coronary Occlusion</u> <u>260x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) <u>Diabetes Mellitus, mild</u>			INTERVAL BETWEEN ONSET AND DEATH <u>MINUTES</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SCHIZOPHRENIA PARANOID TYPE</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1-9</u> , 19 <u>53</u> , to <u>10-14</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10-14</u> , 19 <u>66</u> , and that death occurred at <u>4:30</u> AM, from causes and on the date stated above.			
22a. SIGNATURE <u>Moises Sucholeiki</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Moises Sucholeiki</u>		22d. ADDRESS <u>SPRINGFIELD STATE HOSP. SYKESVILLE MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>10/17/1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Geo. Wash. Cem. Co. Hagerstown, Md.</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>Harry W. Haight Sykesville, Md.</u>		25. REC'D BY REGISTRAR DATE <u>OCT 18 1966</u>	
26. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

14004

14007

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>1yr. 11mos. 29dys.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>			
				d. STREET ADDRESS <b>805 Houston Avenue</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>JAMES WILLIAM MC ELFRESH</b>				4. DATE OF DEATH Month Day Year <b>October 19 19 66</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2- -1898</b>	9. AGE (In years last birthday) yrs. <b>72</b>	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bricklayer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles McElfresh</b>				14. MOTHER'S MAIDEN NAME <b>Cecelia Ferguson</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>Records, Springfield State Hospital</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subacute bacterial endocarditis</b> <b>4221</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome associated with cerebral arteriosclerosis, with behavioral reaction.</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work at work		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <b>10-20-64</b> , 19__, to <b>10-19-66</b> , 19__, that (I) (we) last saw the deceased alive on <b>10-19-66</b> , 19__, and that death occurred at <b>8:35 P.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <i>Octavio A. Ruiz</i> <b>Octavio A. Ruiz, M.D.</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>10-20-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Octavio A. Ruiz, M.D.</b>				22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct 24 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington D.C.</b>	
24. FUNERAL DIRECTOR <i>Arthur Walters</i> <b>Arthur Walters</b>				25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
ADDRESS <b>254 Carroll Street, N.W. Washington, D.C. 20012</b>				DATE <b>OCT 24 1966</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and many event, within 72 hours after death.

14007

EXHIBIT OF DEATH

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14005

## CERTIFICATE OF DEATH

14008

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN lb <b>2 mos. + 2wks</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore city</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>			d. STREET ADDRESS <b>3030 Iona Terrace</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Adam</b> Last <b>Miller</b>			4. DATE OF DEATH Month <b>10</b> Day <b>8</b> Year <b>1966</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-29-96</b>		9. AGE (In years lost birthday) yrs. <b>70</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pharmacist</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>John G. Miller</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes 1919</b>			16. SOCIAL SECURITY NO. <b>212-07-6071</b>		17. INFORMANT <b>Springfield State Hospital Records,</b> Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral Pneumonia</b> DUE TO (b) <b>Uremia</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Psychotic depressive reaction</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>7-21</b> , 19 <b>66</b> , to <b>10-8</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>10-8</b> , 19 <b>66</b> , and that death occurred at <b>8:20 PM</b> , from causes and on the date stated above.					
22a. SIGNATURE <i>Carlos G. Levin</i>			22b. DATE SIGNED <b>10-8-66</b>		22c. PHYSICIAN'S NAME (Type) <b>Carlos G. Levin</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>10/12/66.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>
23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>			24. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc., Balto. Md. 21214</b>		
25a. REC'D BY REGISTRAR DATE <b>OCT 13 1966</b>			25b. REGISTRAR'S SIGNATURE <i>Francis Judge</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.



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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14006

## CERTIFICATE OF DEATH

14009

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Carroll</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN 1b <b>7yrs. 2mos. 1dy.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>616 Dale Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>FRANCES</b> Middle <b>SLATER</b> Last <b>MINSKE</b>			<b>4. DATE OF DEATH</b> Month <b>October</b> Day <b>11</b> Year <b>19 66</b>				
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>B. DATE OF BIRTH</b> <b>05-28-20</b>	<b>9. AGE</b> (In years last birthday) <b>46</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Florida</b>			
<b>13. FATHER'S NAME</b> <b>William S. Lining</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Rayna Slater</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>262-18-0740</b>		<b>17. INFORMANT</b> Address <b>Records, Springfield State Hospital</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Coronary arteriosclerosis with terminal thrombus</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Schizophrenic reaction, paranoid type. Diabetic shock &amp; coma.</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> <b>Years</b> <b>Minutes</b>		
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)				
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o.m. _____ p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____			
<b>20f. (City or town)</b> _____ (County) _____ (State) _____		<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>8-10-59</b> , 19____, <b>to</b> <b>10-11-66</b> , 19____, <b>that (I) (we) last saw the deceased alive on</b> <b>10-11-66</b> , 19____, <b>and that death occurred at</b> <b>8:30 AM</b> <b>from causes and on the date stated above.</b>					
<b>22a. SIGNATURE</b> <b>Dr. Antonius Glahn</b> M.D.			<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>10-11-66</b>		
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Antonius Glahn, M.D.</b>			<b>22d. ADDRESS</b> <b>Springfield State Hospital</b> <b>Sykesville, Maryland 21784</b>				
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>10/14/66.</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Gardens of Faith Cemetery</b>			
<b>23d. LOCATION (City or Town)</b> _____ (County) _____ (State) _____		<b>23d. LOCATION (City or Town)</b> _____ (County) _____ (State) _____					
<b>24. FUNERAL DIRECTOR</b> <b>Leonard J. Ruck Inc. Balto. Md. 21214</b>			<b>25a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>OCT 13 1966</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>CARROLL CO.</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL, WESTMINSTER</b> c. LENGTH OF STAY IN 1b <b>7 YRS.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>BOX 255 RT#1 WESTMINSTER</b>						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL, WESTMINSTER</b> d. STREET ADDRESS <b>BOX 255 RT#1 WESTMINSTER</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>KATHARINE JOHANNA NEHMSMANN</b> First Middle Last						4. DATE OF DEATH <b>OCT. 30 1966</b> Month Day Year					
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>APRIL 6, 1909</b>		9. AGE (In years last birthday) <b>57</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE-WIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MD.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE ALBERT FISHER</b>						14. MOTHER'S MAIDEN NAME <b>CAROLINE EIKENBERG</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>				16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>MR. LOUIS J. NEHMSMANN, JR.</b> Address <b>SAME ADDRESS</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardio-Vascular Disease</b> DUE TO (c) <b>—</b>										INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b> <b>15 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>10-3</b> , 1962, to <b>10-30</b> , 1966, that (I) (we) last saw the deceased alive on <b>10-10</b> , 1966, and that death occurred at <b>6:00 AM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>L. L. Potter</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>10/31/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>L. L. POTTER M.D.</b>						22d. ADDRESS <b>LITTLESTOWN, PA.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>11/2/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HOLY REDEEMER CEM.</b>			23d. LOCATION (City, town or county) (State) <b>BALTIMORE MD.</b>			
24. FUNERAL DIRECTOR <b>J. E. Myers, Jr. Westminster, Md.</b>						25a. REC'D BY REGISTRAR <b>DATE NOV 2 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

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CAROLINE ELLIOTT

GEORGE ALBERT FISHER

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MR. JAMES J. HENNINGSON JR.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

14008

14011

1. PLACE OF DEATH a. COUNTY <u>Carroll Co -</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville Md</u>		c. LENGTH OF STAY IN 1b <u>8 mon.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R#2 Emmitsburg</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>S.S. Hospital.</u>		d. STREET ADDRESS <u>10-2</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Edgar</u> Last <u>Ohler</u>		4. DATE OF DEATH Month <u>10</u> Day <u>16</u> Year <u>1966</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/7/93</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>9</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Emmitsburg, Md (Frederick)</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ohler, John E.</u>		14. MOTHER'S MAIDEN NAME <u>Willard, Catharine</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-12-1985 A</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u></u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>4 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CA of bladder</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <u></u> of work <u></u>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) <u></u> (County) <u></u> (State) <u></u>
21. I certify that (I) (this hospital) attended the deceased from <u>2/17/66</u> to <u>10/16</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>10/16</u> 19 <u>66</u> , and that death occurred at <u>2:40 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Sam P. Wise III</u>		22b. DATE SIGNED <u>10/16/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Sam P. Wise III</u>		22d. ADDRESS <u>SS # Sykesville Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Oct. 19, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. View</u>	23d. LOCATION (City or Town) <u>Emmitsburg, Frederick Co. Md.</u> (County) <u></u> (State) <u></u>
24. FUNERAL DIRECTOR <u>Clarence E. Wilson, Emmitsburg, Md.</u>		25a. REC'D BY REGISTRAR <u>OCT 19 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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FOR STATE  
HEALTH DEPT.

14009

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14012

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hampstead</b>		c. LENGTH OF STAY IN 1b <b>Approx. 1 hr.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glyndon, Md.</b>		03.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Carroll County General Hospital</b>						d. STREET ADDRESS <b>Butler Road</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>ROBERT LEE PEARRE</b>		First Middle Last		4. DATE OF DEATH <b>OCT. 15 1966</b>		Month Day Year		5. AGE (In years last birthday) <b>24 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 22, 1942</b>		9. AGE (In years last birthday) <b>24 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Operator-Machinery</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>William K. Pearre</b>		14. MOTHER'S MAIDEN NAME <b>Fern Bisser</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>212-40-7986</b>		17. INFORMANT <b>Mr. Thomas H. Pearre, 708 Templecliff Rd.</b>		Address <b>Pikesville 8, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured Neck</b> <b>823.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>Car ran off road struck pole upset</b>									
20c. TIME OF INJURY Hour a.m. p.m. <b>10:15 a.m. 10-15 1966</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, place bldg., etc.) <b>State Road</b>		20f. (City or town) (County) (State) <b>Hampstead Carroll Md</b>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>10-15-66</b>	
ACTUAL SIGNATURE <b>W. Glen Peicker</b>		EXAMINER'S NAME (Type) <b>W. Glen Peicker</b>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, etc., county) <b>1355 Main Street Westminster Carroll Md</b>		22. DATE SIGNED <b>10-15-66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct. 18, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION (City, town or county) <b>Woodlawn, Md.</b>		24. FUNERAL DIRECTOR <b>Frank H. Newell, Pikesville 8, Md.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>OCT 20 1966</b>		25c. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25d. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25e. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25f. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

1918

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1918

THE STATE

*[Faint, mostly illegible text and signatures follow, including what appears to be a signature at the bottom right.]*

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FOR STATE  
HEALTH DEPT.

14010  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
14013

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. (File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.)

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN 1b <b>lyr. 4 mos. 3 dys.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>700 McKewin Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Sophia</b> Middle <b>Stella</b> Last <b>Poehler</b>				4. DATE OF DEATH Month <b>October</b> Day <b>25</b> Year <b>1966</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-11-77</b>	
9. AGE (In years last birthday) <b>88</b> yrs.		IF UNDER 1 YEAR Months <b>30</b> Days <b>4</b>		IF UNDER 24 HRS. Hours <b>4</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Albert Behling</b>				14. MOTHER'S MAIDEN NAME <b>Dorothy Haupt</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>212-54-9880</b> <b>220-54-6662</b>		17. INFORMANT <b>Records, Springfield State Hospital</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> 0534 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Multiple infected sores</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome, associated with senile brain disease, without qualifying phrase. Fracture, left hip</b> 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>Patient found to have swollen left leg and foot, cause unknown, on 8-29-66</b> 20c. TIME OF INJURY Month, Day, Year Hour <b>5:30</b> p.m. <b>8-29</b> <b>1966</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Springfield State Hospital</b> 20f. (City or town) (County) (State) <b>Sykesville, Carroll, Md.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>weeks</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>W. Glenn Speicher</i> EXAMINER'S NAME (Type) <b>W. Glenn Speicher, M.D.</b>				22. DATE SIGNED <b>10-25-66</b> <i>Charles Judge</i> ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct. 28, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks, Inc. 1217 St. Paul Street</b> <b>Baltimore 2, Maryland</b>				25a. REC'D BY REGISTRAR <b>OCT 27 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

1994

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14011

## CERTIFICATE OF DEATH

14014

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural--Sykesville</b>			c. LENGTH OF STAY IN lb <b>ly. 1m. 7d.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodsboro</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>none</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ada</b> Middle <b>Bell</b> Last <b>Quick</b>				4. DATE OF DEATH Month <b>10</b> Day <b>9</b> Year <b>1966</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 1988</b>		9. AGE (In years lost birthday) yts. <b>78</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Washington Pettenger</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>220-54-6282</b>		17. INFORMANT Address <b>Springfield Hospital records, Sykesville, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4200 Deep Heart Failure.</b> DUE TO (b) <b>Arteriosclerotic heart disease.</b> DUE TO (c) <b>1 day</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome assoc. c cerebral arteriosclerosis</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>Ada</b> (this hospital) attended the deceased from <b>9/21</b> , 1965, to <b>10/9</b> , 1966, that <b>she</b> (we) last saw the deceased alive on <b>10/9</b> , 1966, and that death occurred at <b>12:30</b> P.M. from causes and on the date stated above.							
22a. SIGNATURE <b>Carlos G. Lavin</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>10/9/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Carlos G. Lavin, M. D.</b>				22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-13-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Creagerstown Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Creagerstown Fred. Co. Md.</b>	
24. FUNERAL DIRECTOR <b>Raymond E. Creager</b>				25a. REC'D BY REGISTRAR DATE <b>OCT 13 1966</b>		25b. REGISTRAR'S SIGNATURE <b>James Judge</b>	



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*Wm. B. Jones*

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14012

## CERTIFICATE OF DEATH

14015

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="font-size: 1.2em;">Carroll</span> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <span style="font-size: 1.2em;">Maryland</span> <span style="float: right;">b. COUNTY</span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">Rural--Sykesville</span>			c. LENGTH OF STAY IN 1b <span style="font-size: 1.2em;">5mo. 22days</span>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">Baltimore</span>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <span style="font-size: 1.2em;">Springfield State Hospital</span>				d. STREET ADDRESS <span style="font-size: 1.2em;">6427 Glenoak Avenue</span>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>3. NAME OF DECEASED</b> (Type or print) <span style="font-size: 1.2em;">Anna Ernestine Reinhardt</span>				<b>4. DATE OF DEATH</b> Month <span style="font-size: 1.2em;">10</span> Day <span style="font-size: 1.2em;">10</span> Year <span style="font-size: 1.2em;">1966</span>			
5. SEX <span style="font-size: 1.2em;">female</span>	6. COLOR OR RACE <span style="font-size: 1.2em;">white</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">10/11/88</span>		9. AGE (In years lost birthday) yrs. <span style="font-size: 1.2em;">77</span>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">housewife</span>			10b. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">housewife</span>		11. BIRTHPLACE (County & State, or foreign country) <span style="font-size: 1.2em;">Maryland</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>
13. FATHER'S NAME <span style="font-size: 1.2em;">Henry Berger</span>				14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Catherine Comes</span>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <span style="font-size: 1.2em;">no</span>			16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">none</span>		17. INFORMANT Address <span style="font-size: 1.2em;">Springfield Hospital records, Sykesville</span>		
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <span style="font-size: 1.2em;">Sepsis</span> <span style="font-size: 1.2em;">7230</span> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <span style="font-size: 1.2em;">Decubitus ulcers due to deforming arthritis</span> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">days</span> <span style="font-size: 1.2em;">months</span>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <span style="font-size: 1.2em;">Chronic brain syndrome associated with senile brain disease with psychotic reaction.</span>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <span style="font-size: 1.2em;">19</span>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that <del>the</del> (this hospital) attended the deceased from <span style="font-size: 1.2em;">4/18/1966</span> to <span style="font-size: 1.2em;">10/10/1966</span> , that <del>he</del> (we) last saw the deceased alive on <span style="font-size: 1.2em;">10/10/1966</span> , and that death occurred at <span style="font-size: 1.2em;">7:30 PM</span> , from causes and on the date stated above.							
22a. SIGNATURE <span style="font-size: 1.2em;">Naci N. Buyukunsal</span>					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <span style="font-size: 1.2em;">10/11/66</span>
22c. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Naci N. Buyukunsal, M. D.</span>					22d. ADDRESS <span style="font-size: 1.2em;">Springfield State Hospital Sykesville, Maryland</span>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		23b. DATE THEREOF <span style="font-size: 1.2em;">10-13-1966</span>		23c. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">Jerusalem Cemetery</span>		23d. LOCATION (City or Town) (County) (State) <span style="font-size: 1.2em;">Baltimore Md.</span>	
24. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">Lassahn Funeral Home 7401 Belair Road</span>				25a. REC'D BY REGISTRAR <span style="font-size: 1.2em;">(34)</span>		25b. REGISTRAR'S SIGNATURE <span style="font-size: 1.2em;">Charles Judge</span>	
DATE <span style="font-size: 1.2em;">OCT 14 1966</span>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

14016

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Carroll</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster</b> c. LENGTH OF STAY IN 1b  d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Carroll County General Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hampstead, Md.</b> d. STREET ADDRESS <b>106 N. Main St.</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>GEORGE DANIEL RESH</b> First Middle Last		<b>4. DATE OF DEATH</b> Month <b>10</b> Day <b>30</b> Year <b>1966</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>10/11/99</b>
<b>9. AGE</b> (In years last birthday) <b>67</b> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Dentist</b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Daniel M. Resh</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Annie Hoffman</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>216-22-7541</b>	
<b>17. INFORMANT</b> <b>Mrs. Louise Resh</b>		Address <b>Hampstead, Md.</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO (b) <b>ACUTE MYOCARDIAL INFARCTION</b> DUE TO (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
INTERVAL BETWEEN ONSET AND DEATH <b>48 HOURS</b> <b>YEARS</b>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>	<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town) (County) (State)</b>
<b>21. I certify that (I) (this hospital) attended the deceased from <u>10/28, 1966</u> to <u>10/30, 1966</u>, that (I) (we) last saw the deceased alive on <u>10/30, 1966</u>, and that death occurred at <u>12</u> M, from causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <i>Vincent J. Kross</i>		<b>22b. DATE SIGNED</b> <b>10/30/66</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b>		<b>22d. ADDRESS</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>11/2/66</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Greenmount Cemetery</b>		<b>23d. LOCATION (City or Town) (County) (State)</b> <b>Greenmount Md.</b>	
<b>24. FUNERAL DIRECTOR</b> <b>Tipton-Eline</b>		ADDRESS <b>Hampstead, Md.</b>	
<b>25a. REC'D BY REGISTRAR</b> DATE <b>NOV 2 1966</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2004

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14014

CERTIFICATE OF DEATH

14017

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural--Sykesville</b>			c. LENGTH OF STAY IN lb <b>5mo. 16days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington Grove</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>119 Maple Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Pearl (NMN) Roberts</b>				4. DATE OF DEATH Month Day Year <b>10 25 19 66</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>01/21/89</b>		9. AGE (In years last birthday) yrs. <b>77</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>? Spicer</b>				14. MOTHER'S MAIDEN NAME <b>Elvina Boyer</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>577-48-1932</b>		17. INFORMANT Address <b>Springfield Hospital records, Sykesville, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobar pneumonia.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Chronic brain syndrome associated with senile brain disease with psychotic reaction.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <b>5/9/</b> , 19 <b>66</b> , to <b>10/25/</b> , 19 <b>66</b> , that (2) (we) last saw the deceased alive on <b>10/25/</b> , 19 <b>66</b> , and that death occurred at <b>11:30 p.m.</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>R. G. Lajonchere M.D.</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>10/25/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>R. G. Lajonchere M.D.</b>				22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-28-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>National Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Falls Church Va.</b>	
24. FUNERAL DIRECTOR <b>Ernest C. Gartner</b>				25a. REC'D BY REGISTRAR DATE <b>OCT 28 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND <b>CERTIFICATE OF DEATH</b>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Carroll</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminster R.D. #4</u> c. LENGTH OF STAY IN 1b <u>60 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Park Road</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminster R.D. #4</u> d. STREET ADDRESS <u>Park Road</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <u>PANSY LAURA ROBERTSON</u> First Middle Last						<b>4. DATE OF DEATH</b> <u>OCT. 14 1966</u> Month Day Year					
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>March 22/1884</u>		<b>9. AGE</b> (In years last birthday) <u>82</u> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>house-wife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Carroll Co. Md.</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Acquilla Magee</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Annie Maria Lockard</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>—</u>		<b>17. INFORMANT</b> <u>Mr. Leslie C. Robertson</u> Address <u>same</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CYSTADELOCARCINOMA OF OVARY</u> <u>1750</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>—</u>											
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>5/10, 1963</u> , to <u>10/14, 1966</u> , that (I) (we) last saw the deceased alive on <u>10/13 1966</u> , and that death occurred at <u>6 AM</u> , from the causes and on the date stated above.											
<b>22a. SIGNATURE</b> <u>William L. Stewart</u>						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>10/14/66</u>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>WILLIAM L. STEWART MD</u>						<b>22d. ADDRESS</b> <u>19 RIDGE RD. WESTMINSTER, MD.</u>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>10/16/66</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Westminster Cemetery</u>		<b>23d. LOCATION (City, town or county)</b> (State) <u>Westminster Md.</u>					
<b>24. FUNERAL DIRECTOR</b> <u>J. S. Myers, Jr.</u> ADDRESS <u>Westminster, Md.</u>						<b>25a. REC'D BY REGISTRAR</b> <u>J. Charles Judge</u>		<b>25b. REGISTRAR'S SIGNATURE</b>			
<b>DATE</b> <u>OCT 18 1966</u>											

14012

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO DEPUTY MEDICAL EXAMINER: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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VR A15ME  
35DD 4-64

<div style="display: flex; justify-content: space-between;"> <div> <p>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p><b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b></p> </div> <div> <p>14016</p> <p>14019</p> </div> </div>											
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <b>Carroll</b> MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b></p> <p>c. LENGTH OF STAY IN 1b <b>4 mos. 5 dys.</b></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b></p>						<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</p> <p>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b></p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b></p> <p>d. STREET ADDRESS <b>506 Woodbourne Ave.</b></p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>					
<p>3. NAME OF DECEASED (Type or print)</p> <p>First <b>ANNA</b> Middle <b>CATHERINE</b> Last <b>ROZWADOWSKA</b></p>				<p>4. DATE OF DEATH</p> <p>Month <b>OCTOBER</b> Day <b>28</b> Year <b>19 66</b></p>							
<p>5. SEX <b>Female</b></p>		<p>6. COLOR OR RACE <b>White</b></p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <b>1-17-05</b></p>		<p>9. AGE (In years last birthday) <b>61</b> yrs.</p>		<p>10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b></p>				<p>10b. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (State or foreign country) <b>Maryland</b></p>		<p>12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b></p>			
<p>13. FATHER'S NAME <b>James Joseph Raska</b></p>						<p>14. MOTHER'S MAIDEN NAME <b>Mary Dworak</b></p>					
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)</p>				<p>16. SOCIAL SECURITY NO. <b>Unk.</b></p>		<p>17. INFORMANT <b>Records, Springfield State Hospital</b> Address</p>					
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b></p> <p>9249 DUE TO <b>Occlusion of air passages by the face being buried in a pillow.</b></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)</p>										<p>INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b></p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Schizophrenic reaction, chronic undifferentiated type</b></p>											
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)</p>							
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b></p>				<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>			
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/></p>											
<p>ACTUAL SIGNATURE <b>W. Glenn Speicher</b></p>						<p>M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></p>					
<p>EXAMINER'S NAME (Type) <b>W. Glenn Speicher, M. D.</b></p>						<p>Address <b>135 E. Main St. Baltimore, Md.</b></p>					
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b></p>		<p>23b. DATE THEREOF <b>10-31-1966</b></p>		<p>23c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART OF JESUS</b></p>		<p>23d. LOCATION (City, town or county) (State) <b>BALTIMORE MARYLAND</b></p>					
<p>24. FUNERAL DIRECTOR <b>JOHN M. WEBER &amp; SONS INC. 401 S. CHESTER ST.</b></p>						<p>25a. REC'D BY REGISTRAR <b>OCT 31 1966</b></p>		<p>25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b></p>			

14013

14013

Springfield State Hospital

October 20, 1913

Female, white, 35 years

Admission

James Joseph Kneen

Admission

Admission

Admission

Admission

Admission

Admission

Admission

Admission

Admission

Admission

Admission

Admission

Admission

Admission

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 9 Film G381 10/18/66 mh

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Carroll County</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>37 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Jennie</b> First Middle Last <b>Schaale</b>		4. DATE OF DEATH Month <b>October</b> Day <b>12</b> Year <b>19 66</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-9-80</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Photographer</b>		9b. AGE (In years last birthday) <b>85 1/2</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Photographer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Photography</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles F. Schaale</b>		14. MOTHER'S MAIDEN NAME <b>Christiana Smith</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>220-54-6914</b>	
17. INFORMANT <b>Med. Record, Springfield Hospital,</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>0021</b> (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Pulmonary tuberculosis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenic Reaction, Paranoid type</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>(X)</del> (this hospital) attended the deceased from <b>8-29-29</b> , 19 <b>66</b> , to <b>10-12</b> , 19 <b>66</b> , that <del>(X)</del> (we) last saw the deceased alive on <b>10-12</b> , 19 <b>66</b> , and that death occurred at <b>1:15 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>R. G. Lajonchere MD</b>		22b. DATE SIGNED <b>10-12-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>R. Lajonchere, M.D.</b>		22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>OCT 15-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>PROSPECT HILL CEM</b>		23d. LOCATION (City or Town) (County) (State) <b>YORK YORK PA</b>	
24. FUNERAL DIRECTOR <b>Harry W. Haight</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>OCT 14 1966</b>	



1950-1951

FIG. 11

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File, pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
3500 4-64

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SVRESVILLE</b> c. LENGTH OF STAY IN 1b <b>5 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRINGFIELD State Hosp.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>-</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CITY</b> d. STREET ADDRESS <b>3937 CLARKS LANE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM (W.M.M.) SCHUMER</b>		4. DATE OF DEATH Month <b>10</b> Day <b>2</b> Year <b>1966</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-27-98</b>	9. AGE (In years last birthday) <b>68</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AUTOMOBILES</b>		11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>DAVID SCHUMER</b>		14. MOTHER'S MAIDEN NAME <b>FANNIE ??</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>214-24-3484A</b>		17. INFORMANT <b>HOSPITAL RECORDS</b> Address <b>S.S. Hospital Sykesville, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute &amp; chronic left ventricular myocardial infarction</b> DUE TO <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Severe coronary arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Old subdural hematoma</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Min. &amp; mos.</b>  <b>Years</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>W. Glenn Speicher</b>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>10-2-66</b>	
EXAMINER'S NAME (Type) <b>W. Glenn Speicher, M. D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (street, city, town, or county) <b>135 E. Main St. Carroll</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>10/4/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>AHAVAS ACHIM VEREIN</b>		23d. LOCATION (City, town or county) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>Johnson &amp; Bros</b>		ADDRESS <b>SW</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>
DATE <b>OCT 5 1966</b>					

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14022

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Carroll Co. Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b> d. STREET ADDRESS <b>5612 Birchwood Ave. #14</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Robert A. Seidel</b>		4. DATE OF DEATH Month <b>10</b> Day <b>30</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/20/1892</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self Employed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>? Seidel</b>		14. MOTHER'S MAIDEN NAME <b>Amelia Wolf</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Mr. Robert W. Seidel 501 Idlewild Rd.</b>	
17. INFORMATION <b>Belair Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Hypertension</b> DUE TO (c) <b>Arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>W. Glenn Speicher</b> EXAMINER'S NAME (Type) <b>W. Glenn Speicher</b>		22. DATE SIGNED <b>10-30-66</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Charles Judge</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/4/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc.</b>		25a. REC'D BY REGISTRAR <b>NOV 2 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

14083

14083

EXAMINER'S CERTIFICATE OF DEATH

ATTESTED BY

ATTESTED BY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14020					14023						
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminster Rt #4</u> c. LENGTH OF STAY in 1b <u>2 weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Hook Road</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminster Rt #5</u> d. STREET ADDRESS <u>Unumtown Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <u>EMMA RUTH SHAFER</u>				4. DATE OF DEATH Month <u>OCT</u> Day <u>1</u> Year <u>1966</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 11, 1909</u>		9. AGE (In years last birthday) <u>56</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>NOT KNOWN</u>				14. MOTHER'S MAIDEN NAME <u>GERTRUDE MASENHEIMER</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mr. Milton S. Shaffer, Westminster, Md.</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatous brain</u> 1601 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma esophagus et.</u> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <u>3 MOS</u> <u>15 MOS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 10, 1966</u> to <u>Oct 1, 1966</u> , that (I) (we) last saw the deceased alive on <u>Sept 30, 1966</u> , and that death occurred at <u>4:20 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Julius Chepko</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/1/66</u>					
22c. PHYSICIAN'S NAME (Type) <u>Julius Chepko</u>				22d. ADDRESS <u>856 W Green St Westminster</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)					
<u>Burial</u>		<u>Oct. 3, 1966</u>		<u>Methodist Burial Center Westminster Rt 5 Md</u>		<u>Westminster Rt 5 Md</u>					
24. FUNERAL DIRECTOR <u>J. S. Myers, Jr. Westminster, Md.</u>				ADDRESS		25a. REC'D BY REGISTRAR DATE <u>OCT 4 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



14053

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14021

CERTIFICATE OF DEATH

14024

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rural) Sykesville</b>		c. LENGTH OF STAY IN 1b <b>26y 10m 12d</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Eddie</b> Middle <b>(NMN)</b> Last <b>Smith</b>		4. DATE OF DEATH Month <b>10</b> Day <b>31</b> Year <b>19 66</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-1-1902-?</b>
9. AGE (In years last birthday) yrs. <b>64</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Orphan--Baltimore-?</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>unknown</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>4201</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenic reaction, paranoid type in a mental defective</b> <b>Chronic pulmonary emphysema</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>--</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>--</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. -- p.m. -- 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>--</b>		20f. (City or town) (County) (State) <b>---</b>	
21. I certify that <del>(x)</del> (this hospital) attended the deceased from <b>12-19</b> , 19 <b>39</b> , to <b>10-31</b> , 19 <b>66</b> that <del>(x)</del> (we) last saw the deceased alive on <b>10-31</b> , 19 <b>66</b> , and that death occurred at <b>7.08</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Heinz H. Klaatsch</b>		22b. DATE SIGNED <b>10-31-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Heinz H. Klaatsch, M.D.</b>		22d. ADDRESS <b>Springfield State Hospital</b> <b>Sykesville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-4-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR <b>Larry W. Knight</b>		25a. REC'D BY REGISTRAR <b>NOV 7 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14022

14025

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural--Sykesville</b>				c. LENGTH OF STAY IN 1b <b>15 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Nellie</b> Middle <b>Mahala</b> Last <b>Storm</b>				4. DATE OF DEATH Month <b>10</b> Day <b>28</b> Year <b>1966</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>01/05/87</b>	
9. AGE (In years lost birthday) yrs. <b>79</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Charles Poole</b>			
14. MOTHER'S MAIDEN NAME <b>Virginia House</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>			
16. SOCIAL SECURITY NO. <b>unknown</b>				17. INFORMANT <b>Springfield Hospital records, Sykesville, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b> DUE TO (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>Chronic brain syndrome associated with senile brain disease without qualifying phrase.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome associated with senile brain disease without qualifying phrase.</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>10/13/1966</b> to <b>10/28/1966</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>10/28/1966</b> , and that death occurred at <b>8:50 a.m.</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>Alfredo M. Labrit</b>				22b. DATE SIGNED <b>10/28/66</b>		22c. PHYSICIAN'S NAME (Type) <b>DR ALFREDO M LABRIT</b>	
22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>				22e. REC'D BY REGISTRAR <b>Charles Judge</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/31/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Monacacy</b>		23d. LOCATION (City or Town) (County) (State) <b>Beallsville Montg. Md.</b>	
24. FUNERAL DIRECTOR <b>Hilton Funeral Home</b>				25. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 should be retained by the hospital or attending physician. Page 2 of 2 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14023

14026

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Carroll</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminster R.D. #4</u>		c. LENGTH OF STAY IN 1b <u>20 yrs.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminster R.D. #4</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cranberry</u>				d. STREET ADDRESS <u>Cranberry</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>ALTIE</u> Middle <u>LEMAIN</u> Last <u>STREUVIG</u>				<b>4. DATE OF DEATH</b> Month <u>OCT.</u> Day <u>17</u> Year <u>1966</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 28, 1893</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Leroy Streuvig</u>				14. MOTHER'S MAIDEN NAME <u>Alice Julian Kroh</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or date of service) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Mrs. Grace Martin</u> Address <u>Same</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular disease &amp; congestive failure</u> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>Arteriosclerosis (hypertension)</u> (c) <u>Paralysis agitans</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Several years</u> <u>years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <u>  </u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>7-13-66</u> to <u>10-17-66</u> , that (I) (we) last saw the deceased alive on <u>10-17-66</u> , and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>W. Glenn Speicher</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10-18-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Westminster Md.</u>				22d. ADDRESS <u>  </u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/19/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Kruters Cemetery Westminster R.D. Md.</u>		23d. LOCATION (City, town or county) (State) <u>  </u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Myers, Jr.</u>				25a. REC'D BY REGISTRAR <u>  </u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>OCT 20 1966</u>							



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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14024

## CERTIFICATE OF DEATH

14027

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rural) Sykesville</b>			c. LENGTH OF STAY IN 1b <b>Oy. 5m 22d</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster, Route #4 21157</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>--</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ernest</b> Middle <b>P.</b> Last <b>Stultz</b>				4. DATE OF DEATH Month <b>10</b> Day <b>6</b> Year <b>19 66</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 3, '82</b>		9. AGE (In years last birthday) <b>78-7</b>	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unk. laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>unk. Carroll County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>unk. William Stultz</b>				14. MOTHER'S MAIDEN NAME <b>unk. Ann ?</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>unk. Sp. Am. War</b>		16. SOCIAL SECURITY NO. <b>212-12-9083</b>		17. INFORMANT <b>Edward P. Geiman</b> Address <b>Westminster, Md. Hospital Records 80 Ridge Road</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> 4201 DUE TO <b>Coronary artery insufficiency</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Acute pyelonephritis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>Years</b> <b>Years</b> <b>Months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome, senile brain disease, with psychotic reaction</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>--</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>--</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>--</b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>--</b>		20f. (City or town) (County) (State) <b>--</b>	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>4-14</b> , 19 <b>66</b> to <b>10-6</b> , 1966, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>10-6</b> , 19 <b>66</b> , and that death occurred at <b>11:25 a.m.</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Heinz H. Klaatsch</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>10-6-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Heinz H. Klaatsch, M.D.</b>				22d. ADDRESS <b>Springfield State Hospital, Sykesville</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>10/10/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. John's Cath. Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Westminster, Carroll, Md.</b>	
24. FUNERAL DIRECTOR <b>J. E. Myers Jr., Westminster, Md.</b>				25a. REC'D BY REGISTRAR <b>OCT 10 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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Figure 1. Schematic diagram of the experimental setup.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14025

14025

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster</b>			c. LENGTH OF STAY IN 1b <b>3 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster (Rural)</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Carroll County General Hospital</b>				d. STREET ADDRESS <b>Westminster, Md. R. D. 6</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Burl</b> Middle <b>Dorsen</b> Last <b>Stutler</b>				4. DATE OF DEATH Month <b>October</b> Day <b>26</b> Year <b>19 66</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/22/1886</b>		9. AGE (In years lost birthday) <b>80</b> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Steel Mill Employee</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Steel Mill</b>		11. BIRTHPLACE (County & State, or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>George Stutler</b>				14. MOTHER'S MAIDEN NAME <b>Amanda Alice Moore</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-07-2505</b>		17. INFORMANT Address <b>R. D. 6</b> <b>Mrs. Catherine B. Stutler, Westminster, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10/23</b> , 19 <b>66</b> , to <b>10/26</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>10/26</b> 19 <b>66</b> , and that death occurred at <b>3:30</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>John S. Harshey</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>10/26/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN S. HARSHEY, M.D.</b>				22d. ADDRESS <b>8 Anchor St. Westminster, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/28/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Marys Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Silver Run, Carroll Co., Md.</b>	
24. FUNERAL DIRECTOR <b>Richard A. Little</b>				ADDRESS <b>Littlestown, Pa.</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 27 1966</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>10da</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		30-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>2902 Guilford Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Catherine</b> Middle <b>Gertrude</b> Last <b>Sweitzer</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>30</b> Year <b>66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-11-1913</b>
9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James/McTeague</b>		14. MOTHER'S MAIDEN NAME <b>Mary Carr</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-10-3922</b>	
17. INFORMANT <b>Springfield Hosp. Records</b>		Address <b>Sykesville Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>5811</b> IMMEDIATE CAUSE (a) <b>Cirrhosis of liver</b> DUE TO <b>Malnutrition</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CBS, alcohol intoxication without qualifying phrase</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Months</b> <b>Months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10-20-66</b> , 19 <b>66</b> , to <b>10-30</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>10-30-66</b> 19 <b>66</b> , and that death occurred at <b>12 noon</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Octavio Ruiz</b>		22b. DATE SIGNED <b>10-30-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Octavio Ruiz, M.D.</b>		22d. ADDRESS <b>Springfield State Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/2/1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b>		25a. REC'D BY REGISTRAR <b>DATE OCT 31 1966</b>	
ADDRESS <b>4905 York Rd. Balto. 12, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



14082

14082

U.S. DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

WASHINGTON, D.C.

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1911

OFFICE OF THE SECRETARY

U.S. DEPARTMENT OF AGRICULTURE

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U.S. DEPARTMENT OF AGRICULTURE

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U.S. DEPARTMENT OF AGRICULTURE

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U.S. DEPARTMENT OF AGRICULTURE

1911

OFFICE OF THE SECRETARY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14027

CERTIFICATE OF DEATH

14030

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>36 Yrs. 8 MO</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>Cambridge</b>	
3. NAME OF DECEASED (Type or print) <b>Charlotte Taber</b>		4. DATE OF DEATH <b>Oct. 11</b> 19 <b>66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>6/27/1897</b>
9. AGE (In years lost birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Adam Lohman</b>		14. MOTHER'S MAIDEN NAME <b>Celia Cook</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-54-6021</b>	
17. INFORMANT <b>Pt's Record</b>		Address <b>Springfield State Hospital</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Metastatic Carcinoma Of The Breast</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2-24-30</b> , 19 <b>60</b> , to <b>10-11-66</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>6:30 p.m.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>R. C. Lajonchere MD</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Rinaldo Lajonchere</b>		22d. ADDRESS <b>Sykesville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/15/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Quincy</b>		23d. LOCATION (City or Town) (County) (State) <b>Quincy, Franklin Penna</b>	
24. FUNERAL DIRECTOR <b>Walter Z. Lyon</b>		ADDRESS <b>Haymarket, Pa.</b>	
25a. REC'D BY REGISTRAR DATE <b>OCT 14 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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REVENUE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14028

14031

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN lb <b>2 1/2 years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Pullen Nursing Home</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodbine</b> d. STREET ADDRESS <b>26-1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>John R. Tucker</b>		4. DATE OF DEATH Month <b>October</b> Day <b>5</b> Year <b>19 66</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 1, 1903</b>	9. AGE (In years last birthday) <b>62 yrs.</b>	IF UNDER 1 YEAR Months <b>6</b> Days <b>2</b> Hours <b>15</b> Min. <b>00</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Track H and</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B. &amp; O. Railroad</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Carroll Co., Md.</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Frank Tucker</b>					
14. MOTHER'S MAIDEN NAME <b>Catherine Hatfield</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>					
16. SOCIAL SECURITY NO. <b>220-03-2726</b>		17. INFORMANT <b>Mrs. George Cromwell Same As Above</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, generalized</b> DUE TO (c) <b>Cardiac failure, Chronic brain syndrome.</b> INTERVAL BETWEEN ONSET AND DEATH <b>1957</b> <b>through</b> <b>Oct. 5, 1966</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>19 57</b> , to <b>Oct. 5</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Oct. 5</b> , 19 <b>66</b> , and that death occurred at <b>6:45 PM</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Howard E. Hall</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Oct. 6, 1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>Howard E. Hall, M.D.</b>		22d. ADDRESS <b>Sykesville, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/8/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive Cemetery</b>			
23d. LOCATION (City, town or county) (State) <b>Carroll Co., Md.</b>		24. FUNERAL DIRECTOR <b>C. M. Waltz</b> ADDRESS <b>Box 241 Sykesville, Md.</b>					
25a. REC'D BY REGISTRAR <b>OCT 10 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

15041

RECEIVED BY MAIL

15041

RECEIVED BY MAIL

CERTIFICATE OF DEATH

14029

Item 2 Film G382

11/15/66 mh

14032

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>				c. LENGTH OF STAY IN lb <u>4 years</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Golden Age Inst Home</u>				d. STREET ADDRESS <u>Knobdelbine Baltimore 304</u>			
3. NAME OF DECEASED (Type or print) <u>Anna Fursball</u>				4. DATE OF DEATH <u>Oct 3 19 66</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 6, 1884</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>?</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Annapolis, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>Gesner</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>215-10-1076</u>			
17. INFORMANT <u>Nursing Home Records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Ch. Myocarditis</u> (c) <u>Gen Arterio Sclerosis</u> DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/1</u> 19 <u>62</u> to <u>Oct 3</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Oct 3</u> 19 <u>66</u> and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>H. H. Martin</u>				22b. DATE SIGNED <u>Oct 3-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>M N MARTIN</u>				22d. ADDRESS <u>Westminster Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10-5-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>David Ridge</u>		23d. LOCATION (City, town or county) (State) <u>Pikesville Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>C.M. WALKER</u>				25. REC'D BY REGISTRAR <u>Charles Judge</u>			
25a. ADDRESS <u>Box 241 Sykesville Md.</u>				25b. REGISTRAR'S SIGNATURE			



11093

11093

*[Faint, mostly illegible handwritten text and markings covering the page. Some words like "MAY 1944" and "11093" are visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14030

CERTIFICATE OF DEATH

14033

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b> 03-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Carroll County General Hospt.</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Russell</b> Middle <b>L.</b> Last <b>Uhler</b>		4. DATE OF DEATH Month <b>10</b> Day <b>21</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 28, 1919</b>
9. AGE (In years last birthday) yrs. <b>46</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer &amp; Truck Driver</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Balto. Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Elmer T. Uhler</b>		14. MOTHER'S MAIDEN NAME <b>Maggie I. Fowble</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-12-2034</b>	
17. INFORMANT <b>Mr. Edgar M. Uhler</b>		Address <b>Reisterstown, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> DUE TO (b) <b>ARTERIO SCLEROTIC CARDIO VASCULAR DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>DISEASE</b>			INTERVAL BETWEEN ONSET AND DEATH <b>22 HRS</b>  <b>YEARS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>10/20, 1966</b> to <b>10/21, 1966</b> , that (I) (we) last saw the deceased alive on <b>10/21, 1966</b> , and that death occurred at <b>1:25</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Vincent J. Kivicki</b>		22b. DATE SIGNED <b>10/21/66</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10/24/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Finksburg Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Finksburg, Md.</b>
24. FUNERAL DIRECTOR <b>J. F. Eline &amp; Sons</b>		25a. REC'D BY REGISTRAR <b>OCT 24 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

14093

REPORT OF CASE

14093

ACUTE MYOGENIC INFARCTION OF THE

ARTERIO-SCLEROTIC CARD VASCULATURE

2009-10-10

10/10/09

10/10/09

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14031

CERTIFICATE OF DEATH

14034

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN 1b <b>Byrs. 2 mos. 27 dys.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b> d. STREET ADDRESS <b>1003 Annapolis Blvd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>EMMA MARIE VARINA</b>		4. DATE OF DEATH Month Day Year <b>October 21 19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-22-80</b>
9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>David Hullett</b>		14. MOTHER'S MAIDEN NAME <b>Rebecca Gillian</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Records, Springfield State Hospital</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>0021</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Chronic pulmonary tuberculosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome associated with cerebral arteriosclerosis, without qualifying phrase.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Weeks</b> <b>Years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>7-24-63</b> , 19__, to <b>10-21-66</b> 19__, that (I) (we) last saw the deceased alive on <b>10-21-66</b> 19__, and that death occurred <b>4:00 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Agustin del Campo.</b> M.D.		22b. DATE SIGNED <b>10-21-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland 21784</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10/25/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Cem</b>	23d. LOCATION (City or Town) (County) (State) <b>Balto Co Md</b>
24. FUNERAL DIRECTOR <b>McCully FH 237 Patapsco Ave 21225</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 24 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>f Charles Judge</b>			

1-10-66

EXTRACT OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
14032  
14035  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Middleburg</u> c. LENGTH OF STAY IN 1b <u>4 1/2 m. 3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Brookfield Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> d. STREET ADDRESS <u>06-1</u>			
3. NAME OF DECEASED (Type or print) First <u>ALICE</u> Middle <u>-</u> Last <u>VON ARN</u>		4. DATE OF DEATH Month <u>OCT.</u> Day <u>31</u> Year <u>1966</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 28 1893</u>		
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Medical Doctor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Budapest, Hungary</u>		12. CITIZEN OF WHAT COUNTRY? <u>?</u>			
13. FATHER'S NAME <u>not known</u>		14. MOTHER'S MAIDEN NAME <u>not known</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>213-24-7648</u>			
17. INFORMANT <u>Records at Brookfield Nursing Home</u>		Address <u>Middleburg, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral atherosclerosis</u> <u>334X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (a), stating the underlying cause last. DUE TO (c) <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Atherosclerotic cardiovascular disease</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> e.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/24/63</u> , 19 <u>  </u> , to <u>Now</u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>10/27/66</u> , 19 <u>  </u> , and that death occurred at <u>2:15 PM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>J. H. Caricofe</u>		M.D. <u>  </u>		22b. DATE SIGNED <u>10/31/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. H. CARICOFE</u>		22d. ADDRESS <u>Union Bridge, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/3/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Carroll County Home Cemetery</u>	
23d. LOCATION (City, town or county) (State) <u>Rural, Westminster, Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Myers, Jr., Westminster, Md.</u>			
24. ADDRESS <u>Westminster, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 2 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



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*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "110000" and "110000" are visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
14033 CERTIFICATE OF DEATH 14036

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Manchester Rural</i> c. LENGTH OF STAY IN b <i>06.1</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Manchester - Rural</i> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Carroll</i> Middle <i>Guy</i> Last <i>Walker</i>		4. DATE OF DEATH Month <i>Oct</i> Day <i>6</i> Year <i>1966</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>June 7 - 1914</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Plumber</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <i>York Co, Pa</i>
13. FATHER'S NAME <i>Preston L Walker</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		17. INFORMANT Address <i>Mrs Ada Walker, Manchester, Md</i>	
16. SOCIAL SECURITY NO. <i>215-10-7481</i>		14. MOTHER'S MAIDEN NAME <i>Ada Kesser</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> 4201 DUE TO <i>atherosclerotic Coronary</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <i>artery Disease</i> (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <i>1 1/2 hrs</i> <i>5 yrs</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) this hospital, attended the deceased from <i>10/4</i> , 19 <i>66</i> , to <i>10/6</i> , 19 <i>66</i> , that (1) (we) last saw the deceased alive on <i>10/4</i> , 19 <i>66</i> , and that death occurred at <i>5:30 AM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>W H Foard</i>		22b. DATE SIGNED <i>10/6/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>W H Foard MD</i>		22d. ADDRESS <i>Manchester, Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>10/9/66</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Steltz Cemetery</i>	23d. LOCATION (City, town or county) (State) <i>Glen Rock, Pa</i>
24. FUNERAL DIRECTOR <i>Tipton-Elvine</i>		25a. REC'D BY REGISTRAR <i>J Charles Judge</i>	
ADDRESS <i>Hampstead, Md</i>		25b. REGISTRAR'S SIGNATURE	
DATE <i>OCT 10 1966</i>			

14030

14030

Charles Judge

VR A15 (4)  
1SM 7-62

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>															
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Carroll</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linehous (Rural)</u>				c. LENGTH OF STAY IN 1b <u>Linehous (Rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linehous (Rural)</u>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Linehous and PO #1</u>				d. STREET ADDRESS <u>Linehous and PO #1</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Daniel</u> Middle <u>P.</u> Last <u>W. H. Dassin</u>				<b>4. DATE OF DEATH</b> Month <u>Oct</u> Day <u>10</u> Year <u>1966</u>											
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Sept 21 1879</u>		<b>9. AGE (In years last birthday)</b> <u>87</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>06</u> Days <u>11</u>		<b>IF UNDER 24 HRS.</b> Hours <u>00</u> Min. <u>00</u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farming</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Farm</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>York Co., Pa</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			
<b>13. FATHER'S NAME</b> <u>Sam S. Hildasun</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Lydia City</u>									
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>				<b>16. SOCIAL SECURITY NO.</b> <u>219 86-0521</u>		<b>17. INFORMANT</b> <u>Mary Hildasun</u>				Address <u>Linehous and PO</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 4221 DUE TO (b) <u>Arteriosclerotic Cardio</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Vascular Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>1 1/2 yrs</u>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town) (County) (State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Feb</u> , 19 <u>52</u> , <b>to</b> <u>10/10</u> , 19 <u>66</u> , <b>that (II) (we) last saw the deceased alive on</b> <u>10/9/</u> 19 <u>66</u> , <b>and that death occurred at</b> <u>6:45 PM</u> , <b>from the causes and on the date stated above.</b>															
<b>22a. SIGNATURE</b> <u>W. H. Foard</u>								<b>22b. DATE SIGNED</b> <u>10/11/66</u>							
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>W. H. Foard M.D.</u>								<b>22d. ADDRESS</b> <u>Manchester, MD</u>							
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>10/13/66</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Joseph's (Stone) Church Burial</u>				<b>23d. LOCATION (City, town or county) (State)</b> <u>York Co</u>					
<b>24. FUNERAL DIRECTOR</b> <u>St. Joseph's</u>				ADDRESS <u>York Road</u>				<b>25a. REC'D BY REGISTRAR</b> DATE <u>OCT 13 1966</u>				<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>			



14184

14184

Daniel P.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14036 Item #8 Film #0381 10/1/66 pc											
CERTIFICATE OF DEATH 14039											
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Frederick</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>						c. LENGTH OF STAY IN 1b <u>13 years</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pullen Nursing Home</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middletown</u>					
d. STREET ADDRESS <u>-</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Joseph</u> Last <u>Wise</u>						4. DATE OF DEATH Month <u>Oct.</u> Day <u>1</u> Year <u>1966</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1872</u> <u>6-5-1871</u>		9. AGE (In years last birthday) <u>94 yrs.</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Harness maker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>leather</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Wise</u>						14. MOTHER'S MAIDEN NAME <u>Amanda Derr</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Mrs. James Hall</u>				Address <u>Sykesville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis, generalized</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Large right inguinal hernia; arteriosclerotic</u> DUE TO (c) <u>Heart Disease; Coronary thrombosis, acute; Cardiac arrest.</u> INTERVAL BETWEEN ONSET AND DEATH <u>1959</u> <u>through</u> <u>Oct. 1, 1966</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1959</u> to <u>Oct. 1</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Oct. 1</u> , 19 <u>66</u> , and that death occurred at <u>5 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Howard E. Hall</u>						22b. DATE SIGNED <u>10-3-66</u>					
22c. PHYSICIAN'S NAME (Type) <u>Howard E. Hall MD</u>						22d. ADDRESS <u>Sykesville, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>10-4-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Christ Evangelical</u>				23d. LOCATION (City, town or county) (State) <u>Middletown Md.</u>	
24. FUNERAL DIRECTOR <u>Harry W. Haight</u>						ADDRESS <u>Sykesville, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>OCT 5 1966</u>											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
14037					14040						
1. PLACE OF DEATH e. COUNTY <b>Carroll</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural-New Windsor</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Bowersox Road</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural-New Windsor</b> d. STREET ADDRESS <b>Bowersox Road</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>DAISY</b>			First <b>B.</b>		Middle <b>YINGLING</b>		Last <b>YINGLING</b>		4. DATE OF DEATH Month <b>10</b> Day <b>29</b> Year <b>1966</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/27/1880</b>		9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>George Zimmerman</b>					14. MOTHER'S MAIDEN NAME <b>Roseann Swartzbaugh</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>218-52-3749</b>		17. INFORMANT Address <b>Mr. James Yingling, New Windsor RD1, Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular disease</b> <b>4221</b> DUE TO <b>Compensation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)										INTERVAL BETWEEN ONSET AND DEATH <b>Several years</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 20, 1964</b> to <b>Oct 29, 1966</b> , that (I) (we) last saw the deceased alive on <b>Oct 28, 1966</b> , and that death occurred at <b>1:30 PM</b> , from the causes and on the date stated above.											
22e. SIGNATURE <b>William J. Fisher</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>10-29-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>William J. Fisher</b>						22d. ADDRESS <b>Westminster Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>11/1/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Manchester Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Manchester Md.</b>			
24. FUNERAL DIRECTOR <b>Tipton-Eline</b>						ADDRESS <b>Hampstead, Md.</b>		25e. REC'D BY REGISTRAR DATE <b>NOV 2 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14038 CERTIFICATE OF DEATH 14041											
1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Run</b> c. LENGTH OF STAY IN 1b <b>Life</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Westminster, Md. R. D. 1</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Run</b> d. STREET ADDRESS <b>Westminster, Md. R. D. 1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Mary Elizabeth Yingling</b>						4. DATE OF DEATH <b>October 2 1966</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/16/1873</b>		9. AGE (in years last birthday) <b>93</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife-housework</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Her own home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Carroll County, Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>William A. Leppo</b>						14. MOTHER'S MAIDEN NAME <b>Sarah J. Koontz</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>220-40-2487</b>		17. INFORMANT <b>Charles A. Leppo, Westminster, Md. R. D. 1</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>332X</b> DUE TO (b) <b>Arterio-sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Influenza</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Semility</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>10 years</b> <b>10 days</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 1</b> , 19 <b>55</b> , to <b>Oct. 2</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Oct. 2</b> , 19 <b>44</b> , and that death occurred at <b>6:30 P.</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>C. L. Billingslea</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>C. L. Billingslea</b>						22d. ADDRESS <b>Westminster, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/5/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Marys Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Silver Run, Carroll Co., Md.</b>			
24. FUNERAL DIRECTOR <b>Richard A. Little Littlestown, PA.</b>						ADDRESS		25a. REC'D BY REGISTRAR <b>OCT 4 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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